

# The Hospital Review

BUSINESS & LEGAL ISSUES FOR HOSPITAL LEADERSHIP

## 12 Best Practices for Successful Hospital Oncology Departments

By Mark Taylor

Hospital-based oncology services, long a mainstay business line, face many challenges as some of those services migrate from hospitals to outpatient surgery centers, physician offices and even to patient homes. Newer drugs, safer surgical procedures and advanced imaging and radiation technology have brought new tools to cancer experts.

While some chemotherapy infusion has been leaving hospitals for years, federal regulators have now allowed some to be performed in outpatient settings.

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## 11 Key Concepts From the Stark Law

By Scott Becker, JD, CPA, Ji Hye Kim, JD, and Jessica Smith, JD

The Stark law prohibits physicians from ordering designated health services for Medicare patients from entities with which the physician, or a family member, has a financial relationship unless an exception applies. This article reviews 11 key concepts under the Stark Law, in the context of changes to the Stark law made by CMS.

### 1. Agreements between providers and referral sources must be in writing

CMS has set forth numerous exceptions to the Stark law. These exceptions permit certain financial relationships between providers of DHS and physician referral sources, so long as certain conditions are met. These exceptions almost uniformly require that the agreement between a provider of DHS and the physician referral source be in writing. For example, the following exceptions

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## 20 Physician Leaders of Hospitals to Know

This is a list of highly-regarded physicians in executive leadership positions at large acute care hospitals.

**Denis A. Cortese, MD.** Dr. Cortese is president and CEO of Mayo Clinic in Rochester, Minn. He received his medical training from Temple University in Philadelphia. He is a diplomate for the American Board of Internal Medicine and the American Board of Internal Medicine — Pulmonary Disease. His professional interests include therapeutic endoscopy techniques including YAG laser therapy, photodynamic therapy, endoscopic brachy-therapy and the use of endoscopic stents. Dr. Cortese has a longstanding interest in health policy and healthcare delivery. His memberships include the Institute of Medicine of the National Academy of Sciences, the Roundtable on Evidence Based Medicine, Healthcare Leadership Council, Harvard/Kennedy Healthcare Policy Group,

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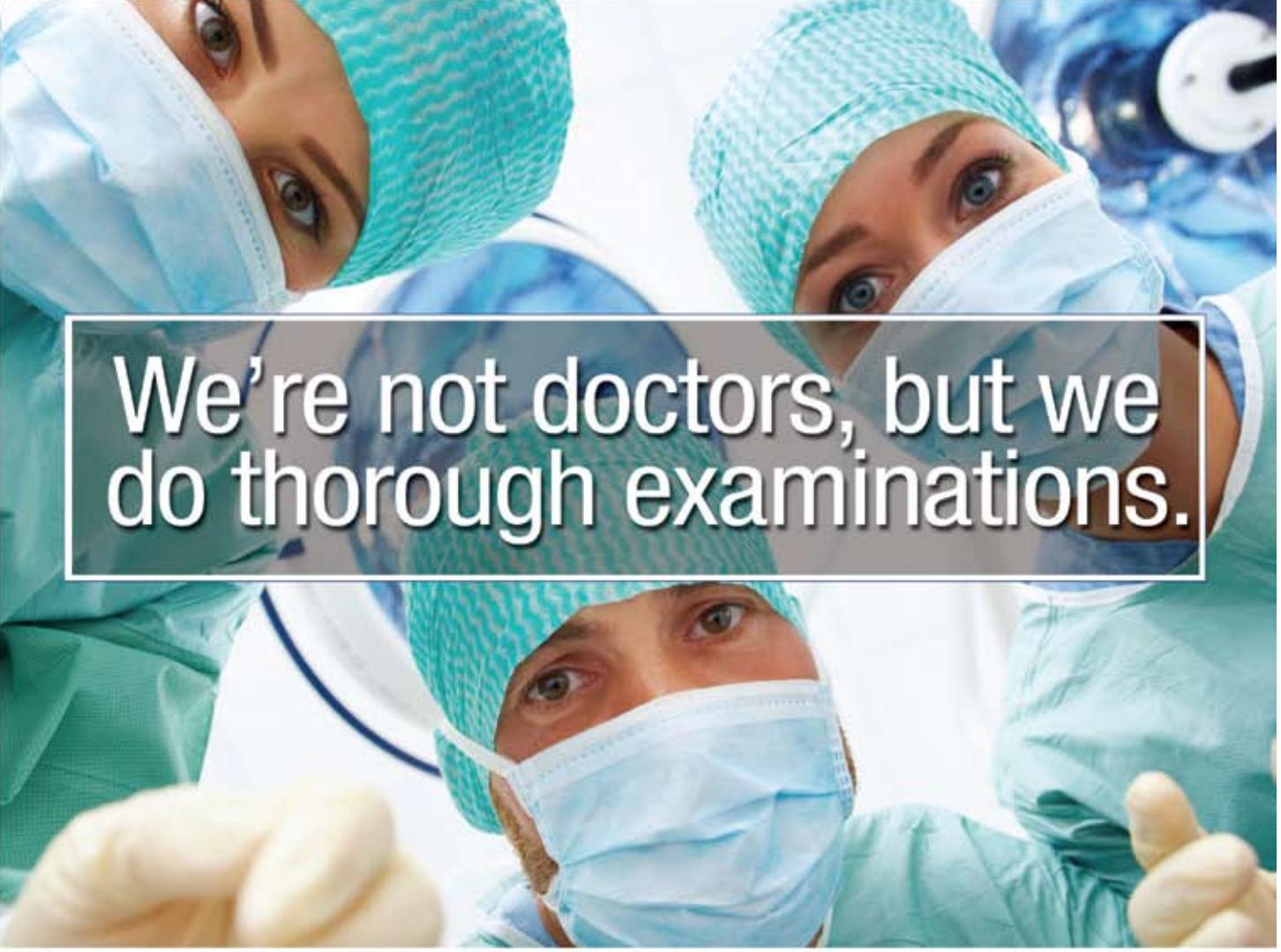


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# The Hospital Review

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# Publisher's Letter

**Consolidations Increasing - Buyouts Stagnant; 7 Key Legal Areas for 2009; ASC Communications and the ASC Association June Orthopedic, Spine and Pain Management Driven ASC Conference – June 11-13, Chicago, Westin Michigan Avenue – \$200/\$100 Discounts on Registrations Available**

This letter offers a handful of observations one can make as this year starts to evolve. It discusses three papers which are available upon request. It also provides information about 27 of the 68 sessions and discounts for our June Orthopedic, Spine and Pain Management Driven ASC Conference.

## I. Two overall observations

**1. Consolidation of providers and businesses.** This year we are seeing more transactions where two providers or several providers are consolidating operations to provide for greater revenues over a single platform. This is as opposed to transactions where a seller is cashing out at a high multiple of EBITDA. The consolidation transactions are being done among ASCs, hospitals (e.g., two hospitals in Rhode Island just announced their merger), group practices and healthcare companies. We are also seeing hospitals increasingly acquiring and/or combining with ASCs and practices.

**2. Seven key legal issues and areas for 2009.** We see the following as seven key legal areas of concern for hospitals, ASCs and practices in 2009.

**(i) Data mining.** We expect increased enforcement as the government uses government data and data mining more fully to pursue both billing fraud and anti-kickback cases. The cases are being driven by both whistleblowers and by the government's own investigations. Here, the government is increasingly using data mining to drive enforcement and to detect patterns in billing that differ from norms. We are also seeing qui tam cases and private party complaints leading to more complete investigations.

**(ii) Recovery Audit Contractors.** There is substantial concern among hospitals that data entry errors and other errors will provide ammunition for RACs. The RAC program is set to recommence this March. There is a great deal of focus on items that can be picked up by the use of computers and data mining — heavy on data use as opposed to relationship-kickback type crime.

**(iii) Stark Act concerns.** Here, there is little wiggle room for technical violations, and a backlog of Stark cases at CMS. We are seeing more overall activity here than ever before. For a copy of a white paper on "11 Stark Issues," see below.

**(iv) Medicaid enforcement.** False claims and similar efforts are being unveiled at state levels to fight fraud and to drive state false claims act recoveries. We have seen states (such as Illinois) take new approaches to kickback and false claim cases and unique positions on fee splitting and kickback cases.

**(v) Quality of care.** We see more cases being brought against providers by regulators based on substandard quality of care. We have one such investigation that is currently ongoing.

**(vi) Anti-kickback cases.** These are a variant of Stark Act cases but subject to a different standard of proof of intent and not just applicable to physicians.

**(vii) Tax-exempt compensation and community benefits.** The IRS recently completed a study that indicates that the average CEO compensation at the 500 hospitals it reviewed was \$490,000. It also found compensation on average of \$1.4 million at the top 20 hospitals. Finally, it found that approximately 10 percent of all hospitals provided nearly 60 percent of all community benefits as measured by the IRS.

## II. White papers available — No charge

We have recently completed three white papers and articles that are available upon request. If you have an interest in obtaining a copy of any of the following, please contact me and we would be happy to provide you a copy of the same.

**1. Developing Centers of Excellence — Strategies and Tactics.** This is an article regarding developing centers of excellence. It focuses on both developing a strategic vision and the tactics to be used in developing specialty driven centers of excellence. This was drafted from a presentation we gave at a conference in February devoted to developing orthopedic-driven centers of excellence. The talk was well received. If you would like a copy of the paper, please e-mail me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or Kirsten Doell at [kdoell@mcguirewoods.com](mailto:kdoell@mcguirewoods.com).

**2. ASC — An Overview and Primer on Key Issues.** This paper was drafted as part of a presentation for both the American Health Lawyers Association and for the February issue of *Becker's ASC Review*. It discusses pricing of surgery centers as well as the key legal agreements and legal and business issues related to such transactions. Should you desire a copy of this paper or a copy of the February issue of *Becker's ASC Review*, please e-mail me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or Kirsten Doell at [kdoell@mcguirewoods.com](mailto:kdoell@mcguirewoods.com). Also, please feel free to visit [www.BeckersASC.com](http://www.BeckersASC.com).

**3. 11 Key Concepts from the Stark Act.** As we review different Stark issues for clients, we see more different and interesting issues than ever before. These relate to such items as lithotripsy, agreements that are not in writing, per-click arrangements, the impact of the "Stand in the Shoes" rules on hospital relationships with their subsidiaries and several other issues. Should you desire a copy of this paper, please e-mail me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or Kirsten Doell at [kdoell@mcguirewoods.com](mailto:kdoell@mcguirewoods.com).

## III. 7th Annual Orthopedic, Spine, and Pain Management Driven ASC Conference

This June we are hosting our 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference. The conference is June 11-13. For this conference, we have 94 speakers, 68 sessions, 30 CEOs and 24 physician leaders speaking. We also have great topics and should have a great turnout. Here are just 27 of the topics covered at the conference:

1. The Evolution of Healthcare and the Impact on ASCs — *Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University*
2. Orthopedics - The Forecast for the Next Five Years — *John Cherf, MD, Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago*
3. Using Spine as the Backbone of a Multi-Specialty ASC — *James Lynch, MD, Surgery Center of Reno*
4. 7 Steps to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy — *Brent Lambert, MD, CEO, Ambulatory Surgical Centers of America*
5. Case Study — Two Years Later, A Physician-Owned Spine ASC: A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems — *John Caruso, MD, Parkway Surgery Center, Hagerstown, Maryland*
6. A Payer's View of Orthopedics, Spine and Pain Management — *Steven Stern, MD, VP Neuroscience, Orthopedics and Spine, United Healthcare*
7. A Case Study Review of Current Outcomes and Issues — *Marcus Williamson, MD, and George Goodwin, SVP and Chief Development Officer, Symbion Healthcare*
8. Making Big Cases Profitable in an ASC — *Naya Kehayes, CEO, Eveia Healthcare; and Greg Cunniff, CFO, National Surgical Care*
9. Using Orthopedics and Spine to Turn Around an ASC — *Tom Mallon, CEO, and Jeff Simmons, President Western Division, Regent Surgical Health*

10. Capturing Your Partners' Cases: The Carrot and Stick Approach — *Chris Bishop, VP, Ambulatory Surgical Centers of America*
11. Key Legal Issues: Safe Harbor Compliance, Out of Network and Other Legal Issues — *Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods*
12. How Economic Conditions Impact Health Care Strategies for Success — *Tom Geiser, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates*
13. Uni Knees and Shoulders in the Outpatient Setting: Cost, Staffing and Profitability Issues — *Peter Kurzweil, MD, and Margarita de Jesus, Administrator, Surgery Center of Long Beach*
14. Key Issues Faced by ASCs Today — *Thomas Yerden, CEO and Founder, TRY HealthCare Solutions*
15. The Pros and Cons of Total Knees in a 23-Hour Setting: Financial and Safety Issues — *Eric Monesmith, MD, OrthoIndy; and John Martin, CEO, OrthoIndy*
16. Pain Management: 5 Keys to a Superior Pain Management Program Surgery Center — *Lance Lehmann, MD, Medical Director, and Liliana Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center*
17. Implant Costs: Why Facility-Physician Collaboration Makes Sense — *Karen Barrow, SVP Business Development, Amerinet*
18. Hand Surgery in ASCs – Key Concepts for Success — *Ed Rudisill, MD, The Hand Center, Greenville, SC*
19. Pain Management in ASCs - Current Methods to Increase Profits — *Amy Mowles, President & CEO, Mowles Medical Practice Management*
20. 5 Tips for Managing Anesthesia in Your ASC — *Thomas Yerden, CEO and Founder, TRY HealthCare Solutions*
21. How to Recruit Great Surgeons to Work at Your ASC — *Robert Carrera, President, Pinnacle III*
22. Turnarounds: 2 Case Studies; 5 Key Ideas for Success — *Joe Zasa, President, Woodrum/ASD*
23. What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away — *Bill Kennedy, SVP Business Development, NovaMed; Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion*
24. Is Your Center Too Dependent on a Single Specialty? How to Diversify and Make Change Happen — *John Seitz, CEO, Ambulatory Surgical Group; Joe Zasa, President, Woodrum/ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare*
25. 5 Core Concepts for Great ASC Joint Ventures With Hospital Partners — *Mike Pankey, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing*
26. Assessing the Profitability of Orthopedics, Spine and Pain in ASCS — *Luke Lambert, CEO, Ambulatory Surgery Centers of America*
27. 5 Core Strategies to Immediately Improve ASC and Hospital Operations — *Doug Johnson, COO, RMC MedStone Capital*

Should you have questions about the conference or desire to see a copy of the brochure, please contact me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or go to [www.BeckersASC.com](http://www.BeckersASC.com). In addition, should you desire to register for the conference, please feel free to deduct \$100 from the registration price if registering for the main conference. Please deduct \$200 if registering for the combined pre-conference and main conference. Please note on the registration, \$100 (main conference only) or \$200 (for main and pre-conference) discount per Scott Becker.

Should you have any questions, please contact me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or at (312) 750-6016.

Very truly yours,



Scott Becker

## **12 Best Practices for Successful Hospital Oncology Departments (continued from page 1)**

But healthcare consultants, hospital administrators, pharmacists and physician oncology experts say there remain plenty of opportunities for hospitals to hold onto and even expand their market share. The cost of some technology is more easily absorbed by hospitals and some have joint-ventured with physicians to deliver high quality, state-of-the-art cancer care.

Here are 12 best practices from 10 respected oncology experts on how hospitals can improve the quality, efficiency, patient satisfaction and financial health of hospital oncology programs.

### **1. Consolidate oncology services into a single center focusing on cancer care.**

Goshen, Ind., was probably best known as the hometown of Jazz-Era writer Ring Lardner. Not anymore. Now patients come from five states to this Northern Indiana city of 30,000 to access world-class care in a hospital cancer center led by a former National Cancer Institute official.

James Dague, president and CEO of the Goshen Health System, said the hospital had three weeks of cash in reserve 14 years ago when its board de-

cided to invest in building the Goshen Center for Cancer Care, which opened in 1998. The 30,000 square-foot facility offers separate entrances for the cancer program and the Goshen Hospital's inpatient unit for oncology patients.

"It's a convenience aspect for patients, a kind of one-stop shopping," Mr. Dague says. "Patients can come to one site and complete all their physician appointments, review their treatment plan and have their lab and diagnostic tests in one place, something really difficult to do in multiple settings."

He says the cancer center has become a regional cancer treatment facility, a destination hospital that has grown by 17-22 percent annually since opening. Mr. Dague says the staff was lured by Cancer Center Medical Director Douglas Schwartzenruber, MD, a surgical oncologist and former official with the National Institutes of Health and the National Cancer Institute.

"The hospital is experiencing a halo effect from the cancer center," Mr. Dague says. "The hospital is seeing more types of patients because of the quality reputation the cancer center has created."

Mr. Dague says the cancer center generates about 30 percent of the hospital's revenue, contributing

significantly to the hospital's \$9.8 million net income on 2008 total revenue of \$190 million. He says the cancer center's integrated, multi-disciplinary delivery model and focus on research and evidence-based protocols have attracted clinical trials from drug and medical equipment producers, programs that not only generate revenue, but allow patients to benefit from cutting-edge science and technology.

"We treat the whole person in one setting, not just with conventional modalities of specialty and sub-specialty care that includes radiation, oncology, surgery and the latest diagnostic imaging equipment, but also their family, social and spiritual needs," says Dr. Schwartzenruber. "We can only cure a limited number of patients with cancer, but we can offer healing to everyone."

### **2. Build the cancer program around the patient.**

Every Monday morning specialists and primary care physicians meet at the Goshen Center for Cancer Care to discuss cancer patients. Every Wednesday all the players — nurses, physicians ranging from radiologists to naturopaths, nutritionists, physicists, counselors and others — meet to discuss each patient's care.

"It's a coordinated approach that has worked well for our patients," Dr. Schwartzenruber says,

pointing out that Goshen's cancer center routinely records patient satisfaction score averages that exceed 95 percent. "We're giving the patients what they're asking for. Our healthcare system is so fragmented and harried that in most hospitals doctors are lucky if they talk to each other at all."

The meetings not only connect the healthcare providers to focus on patient progress, but also serve to coordinate care to reduce errors and improve quality.

**3. Adopt a salaried physician model to focus on cancer care.** Goshen Center for Cancer Care employs a salaried physician model, which Dr. Schwartzenruber says removes some incentives for doctors to over utilize testing or skimp on spending time with patients.

"You have to bring value to physicians," he says. "It has to be more than an income. With increasing regulations, quality reporting data and financial pressures, the more you can remove those burdens from physicians, the happier they are. If you can provide a mechanism so they can practice medicine, conduct research and create an excitement for the practice of medicine, that is a value physicians are willing to accept. And the decreasing reimbursements paid to physicians diminish some of the allure of entrepreneurship. The focus of our physician staff is on quality and innovation and excellent patient care. The business side I leave to our administrative team. We know we can focus on patients and do what's right. And if we put quality first, the rest will follow."

Dr. Schwartzenruber says the salaried physician model also eliminates the inevitable turf battles that result when physician specialists compete for patients.

"Our care team members gather to decide the best course of treatment for patients and there's no competition because there's no economic incentive," he says. "The physicians don't own any of the equipment. And whether the surgeon or urologic oncologist gets the patient doesn't affect their salaries. We've taken the competitive financial pressure out of the decision-making process to find the best course of treatment for that patient."

**4. Recruit cancer sub-specialists to develop and grow niches in breast, melanoma, prostate or other cancers.** Jim Unland, president of the Chicago-based Health Capital Group and a longtime hospital financial consultant, says bringing in cancer specialists and sub-specialists allows hospitals to maintain and even grow market share. Mr. Unland says that patients will travel to find high quality specialty care, noting that quality specialists attract patients, both locally, regionally and nationally. He says patients have grown more sophisticated in navigating the health system and use the Internet, medical libraries and online support groups to access information.

"Generally the physicians are attracted to our delivery model," Dr. Schwartzenruber says. "As our team has grown at Goshen's cancer center, we've brought in physicians with unique specialties. I'm primarily treating patients with melanoma, which comprises something like 4 percent of all cancers. But we get people from all over to come here. We also offer a unique type of radiation treatment for liver cancer and have received referrals from around the country, even from overseas. We offer technology that not all places have and we have trained staff that knows how to use it. When we bought a particular robot, we also brought in the urologic oncologist at the same time who is considered an expert on it."

**5. Review hospital chargemasters to insure that claims for chemotherapy drugs are billed correctly by increment.** Ernest Anderson, president of the Association of Community Cancer Centers (ACCC) and the director of pharmacy for the Burlington, Mass.-based Lahey Clinic, says many hospitals lack systems to verify that their filed claims are correct. Because of that, many are underbilling and leaving money on the table. Mr. Anderson says sometimes the hospital chargemaster is the culprit.

"With the high cost of cancer drugs, we need to make sure hospitals are maximizing reimbursement by billing correctly," Mr. Anderson says. "It is a relatively complex process and small errors add up to a lot. We need to make sure the increments are set correct and billed appropriately."

**6. Thoroughly understand the cancer care revenue stream.** George Kovach, MD, a medical oncologist and partner in Davenport, Iowa-based Hematology Oncology Consultants, says too many hospitals narrowly define the revenue stream produced from oncology.

"They just look at chemotherapy, but that's just one piece" of oncology, says Dr. Kovach. "They need to consider consults and admissions and X-rays and surgical services, radiation therapy, you count that whole thing as part of your revenue stream. The key thing is not duplicating services, having multiple this and that. You need to build trust."

Dr. Kovach is one of six oncologists on staff at Genesis Health System in Davenport, which operates a private practice within the hospital performing infusion therapy.

"The hospital owns everything and we rent space. The trust we share is not an anomaly," he says, explaining that changes in reimbursement for infusion therapy mean physicians can lose money treating some patients.

"We try to do as much as we can, giving the hospital some solid business in exchange for sending them indigent patients we lose money on," he says. "Because if the hospital loses money, patients will go untreated and it will create a bigger problem for everyone. We try to give the hospital winners

along with losers. Anyone who tries to dump on hospitals without tempering those losses with good-paying referrals will cause strains."

**7. Closely examine billing rejections to learn why claims are denied.** Mr. Anderson of ACCC says bills are sometimes rejected by payors because they are generated by two or more different hospital computer systems, such as pharmacy and nursing. Mr. Anderson says that even though claims may be valid and the services were performed and delivered appropriately, payors could still deny them.

"Often it's because something was misdated, particularly relating to billing for injections. If they were not billed for the same date, one component could be denied," he says. "We've corrected our processes to ensure dating is appropriate and always matches. It's bad enough that reimbursement is low, but if hospitals are billing incorrectly, that's a sin."

**8. Keep a clinical fact sheet protocol on every patient.** Ed Zagol, associate director for clinical oncology at Jordan Hospital in Plymouth, Mass., says that fact sheet records when the patient was last treated and when the next treatment is due, what is prepared and other descriptions that improve the efficiency of the chemotherapy treatment process.

"We try not to miss a patient," Zagol says. "Before we implemented the schedule, we didn't know when the patient was due next for treatment. Now a reminder is a part of the process."

Mr. Zagol says another component of Jordan's program is an advanced order program that allows chemotherapy patients to telephone their arrival time so their drugs are ready when they arrive.

"There's no lost time in the waiting room while the preparation is done," he says. "The patients like it because they feel in control of their chemo process and appreciate not having to wait. Chemo mixtures can cost \$2,000 to \$3,000 and are targeted for a particular patient, so we don't want to prepare it in advance unless we know for sure that the patient will be there for their treatment. We have to be fiscally responsible."

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"It also reduces waste," Mr. Zagol says. "Patients know that by calling in advance they won't have to wait, so there's an incentive for them to call, and most do. One patient comes in five days in a row. I arrive at 6:30 a.m. and at 6:31 a.m. he calls."

**9. Invest in healthcare technology.** Janet Nelson, a veteran oncology nurse, practice consultant and executive who now serves as the chief operating officer of Dallas-based NexGen Oncology, says partnering with physicians is key to the success of any hospital oncology program.

"And to do that you must have cutting-edge technology tying together medical records across the patient care continuum, technology that can access insurance information, PET scan and X-ray results and the latest lab tests in a platform in which all the clinicians can interact and share information in real time," she says. Ms. Nelson says NexGen is "heavily invested in clinical informatics," which she calls "the new front end to the oncology experience."

She says having that system enables NexGen staff to broaden its geographic reach and participate in telemedicine initiatives.

"Investing in technology is a huge expense, but it will improve efficiency, quality and the patient experience," she says. "America's healthcare sys-

tem is still set up in silos now, but this is the model of the future."

**10. Use patient navigators to improve patient satisfaction.** JoAnn Lovins, director of oncology services for Poudre Valley Hospital in Fort Collins, Colo., says patient navigators, who are oncology nurses that connect patients to transportation, social services and work with them on co-pays and other insurance issues and access to drugs, optimize how patients get through the cancer treatment process.

"With the support services and funding, it's almost too much for patients to handle," Ms. Lovins says. "Patient navigators make the whole process easier to handle, more efficient and end up paying for themselves. A new cancer patient averages 70 visits the first year of diagnosis from the first screening. When we listened to the voices of our customers, we heard that the handoffs and connections were difficult. Finance becomes an issue very fast. Our doctors were saying we need an oncology nurse available 24/7 to hold patients' hands and we listened to our physician partners. There are many barriers. And the primary mission of patient navigators is to remove barriers and enhance timely access to cancer care, to help them through the struggle."

Ms. Lovins says Poudre Valley secured \$250,000 in foundation grants to assist patients with drugs, daily life expenses and payments to doctors and the hospital.

"If patients need to go from commercial insurance to government insurance, we help to move them along in a timely fashion," says Ms. Lovins. "When I had to justify these positions, I showed that the income coming in from having these navigators helps us access grants to directly cover treatments, instead of having these patients going on charity care. Our physician partners benefit, too."

She says Poudre Valley, the only U.S. hospital to win the coveted Malcolm Baldrige Award (from the U.S. National Institute of Standards and Technology) in 2008, hired oncology nurses as patient navigators "because they know how difficult the process can be."

**11. Reduce delinquent billing.** Herb DeBarba, the vice president of Lean Operations for Schaumburg, Ill.-based Cancer Treatment Centers of America (CTCA), says the company cut its delinquent billing by 93 percent by reducing the time and error associated with billing and coding.

"We did that in less than 26 days by monitoring the time from when service was rendered to the time when the account was charged and tracked that accuracy rate," Mr. DeBarba says. He says the privately-held firm, which has adopted Six Sigma and Toyota's "Lean" continuous quality improvement programs, moved to 'real-time charging,' also known as posting. Previously it sometimes waited until the end of a shift or the next day to bill a claim.

"If we can streamline quality activities together without the waiting time, the accuracy is much improved," says Mr. DeBarba, who points out that CTCA has reduced the actual time it takes to bill a claim by 33 percent.

**12. Expand infusion center capacity.** CTCA's Mr. DeBarba says the company increased the capacity of its infusion centers by 32 percent without staffing increases by examining and streamlining its processes by using a value stream map, a process map that identifies value-added steps.

"Once we identify what's not of value, we work to eliminate it," he says. "Now when a patient walks into one of our infusion centers, he or she is greeted by name, a patient care technician is immediately summoned and can begin vitals right away. The patient care technician introduces the patient to the infusion nurse who lets the patient select a chair, and within 20 minutes of arrival we can hang the infusion bag. We've reduced waiting time and improved handoffs and patient satisfaction. We are relentless in pursuit of customer intelligence."

He says there are financial benefits to providing excellent care. "But that's not why we do this," Mr. DeBarba says. "When you eliminate non-value-added activity, not only do your costs go down, but you improve patient loyalty." ■

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## **11 Key Concepts from the Stark Law (continued from page 1)**

to the Stark law require a written, signed agreement: office space and equipment rental, personal service arrangements, physician recruitment arrangements, group practice arrangements and fair market value compensation arrangements. 42 C.F.R. 411.357.

CMS has indicated that the purpose of requiring a written agreement is “so that [the agreement] can be objectively verified, and meets the terms and conditions of [the exception.]” 66 F.R. 949 (Jan. 4, 2001). The inadvertent error of not placing an excepted financial relationship in writing generally means that the arrangement will not meet an exception, even if all other requirements of the given exception were satisfied.

The key excepted financial relationship that need not be in writing is for bona fide employment relationships. 42 C.F.R. 411.357(c).

### **2. Per-click leasing arrangements**

As of Oct. 1, physician referral sources and providers of DHS will no longer be permitted to have per-click relationships for office space and equipment leases. Four exceptions currently permit these types of arrangements: the office

space exception, the equipment lease exception, the fair market value exception and the indirect compensation arrangement exception. 411 C.F.R. 411.357(a), (b), (l), and (p).

The 2009 Hospital Inpatient Prospective Payment System final rule modified these exceptions to explicitly exclude per click arrangements for lease of equipment or real estate. 73 F.R. 48343 (Aug. 19, 2008). CMS limited per-click leasing arrangements in large part due to its concern that “such lease arrangements create the incentive for overutilization, because the more referrals the physician lessor makes, the more revenue he or she earns.” 73 F.R. 48715 (Aug. 19, 2008).

These changes that prohibit per-click office space and equipment leasing arrangements will go into effect on Oct. 1, 2009. Any existing per-click office space or equipment lease arrangement that relies on one of these exceptions will need to be restructured prior to the Oct. 1, 2009, compliance deadline.

### **3. Percentage-based arrangements**

The revisions to Stark law made by the IPPS do not extend to percentage-based compensation formulae outside of the office space and equipment lease context. Thus, “if a compensation formula for physician compensation for items

or services — other than the rental of office space or equipment — was permissible prior to Oct. 1, 2009 ... that formula would not be made impermissible by this final rule.” 73 F.R. 48712 (Aug. 19, 2008).

For example, percentage-based management and billing service relationships are still permissible so long as they satisfy certain criteria set forth in the Stark law and anti-kickback statute.

CMS has indicated, however, that the prohibition on percentage-based compensation arrangements may be extended outside of the office space and equipment lease context: “although we are not extending, at this time, the prohibition on the use of percentage-based compensation formulae to arrangements for any non-professional service (such as management or billing services), we reiterate our intention to continue to monitor arrangements for nonprofessional services that are based on a percentage of revenue raised, earned, billed, collected or otherwise attributable to a physician’s (or physician organization’s) professional services.” 73 F.R. 48710 (Aug. 19, 2008).

### **4. Lithotripsy arrangements**

As mentioned, the Stark law prohibits physicians from ordering DHS for Medicare patients from

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entities with which the physician has a financial relationship. Lithotripsy services are not considered DHS. *Am. Lithotripsy Soc. v. Thompson*, 215 F. Supp. 2d 23 (D.D.C. 2002). The IPPS commentary confirms this analysis, suggesting that lithotripsy services are not DHS regardless of whether the services are billed by the provider or a hospital. 73 F.R. 48730 (Aug. 19, 2008). As a result, the upcoming prohibition on per-click leasing arrangements will not apply to lithotripsy lease arrangements or under-arrangement agreements. CMS draws a very significant distinction between leases of equipment which can generally no longer be per-click and services agreements which include some equipment therein, and can be per-click or per-service. In the case of lithotripsy, the distinction is critical to whether urologists can make other DHS referrals to the hospital.

A urologist who leases a lithotripter to a hospital through a leasing agreement on a per-click basis cannot make other referrals to that hospital (i.e., other referrals outside of lithotripsy). Per-click leasing agreements, in short, will not meet an exception and thus the urologist cannot make other referrals. A per-click lithotripsy agreement, in contrast, that provides overall lithotripsy services (not just equipment) may be structured to fit into the fair market value exception. Thus, the urologist would be able to arguably make other referrals to the hospital.

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In the case of a local urologist providing lithotripsy services to a hospital at which he or she generally practices, the key question will come down is the agreement a lease of equipment or a service agreement.

Two key comments from CMS as to this issue are as follows:

- Currently, lithotripsy is not considered a designated health service for purpose of the physician self-referral law. Therefore, if the physician owners of the lithotripsy partnership make referrals to the hospital for lithotripsy services ONLY, the physician self-referral law would not be implicated, and a per-unit or percentage-based compensation formula for the compensation arrangement between the lithotripsy partnership and the hospital would be prohibited, even if the compensation arrangement is considered to be a lease of equipment (and other items or personnel).
- If the physician owners of the lithotripsy partnership refer Medicare patients to the contracting hospital for any DHS, the compensation arrangement between the lithotripsy partnership and the hospital must comply with an applicable exception to the physician self referral law. Where a compensation arrangement between the hospital and the physician-owned lithotripsy partnership is considered to be a lease of equipment, a per-unit or percentage-based compensation formula would fail to satisfy the requirements of any of the potentially applicable exceptions for the lease of equipment found in §411.357(b), §411.357(l) or §411.357(p).

## 5. Professional courtesy

CMS recognized the longstanding tradition of extending professional courtesy to physicians and their family members in 2004 by promulgating an exception to the Stark law for professional courtesy arrangements. 69 F.R. 16116 (March 26, 2004). The professional courtesy exception covers free or discount services provided to a physician or his or her immediate family members, so long as certain conditions are satisfied. 42 C.F.R. 411.351.

Specifically, the arrangement must be: (i) extended to all physicians on the medical staff or in the community; (ii) for items and services routinely provided by the entity; (iii) set forth in writing and approved by the provider's governing body; (iv) unavailable to any physician or family member who is a federal health care program beneficiary; and (v) does not violate the anti-kickback statute or any billing or claims submission laws. 42 C.F.R. 411.357(s).

## 6. Retention payments

A hospital, federally qualified health center or rural health clinic may make retention payments to physicians in order to induce them to stay in its geographic service area. Retention payments may be made when a physician has a bona fide offer or presents a written certification that he or she has a recruitment opportunity that would require the physician to relocate at least 25 miles outside of the entity's geographic service area. 42 C.F.R. 411.357(t).

The Stark law recently added more flexibility to the retention payments exception by widening the "geographic service area." 72 F.R. 51065 (Sept. 5, 2007). The entity's "geographic service area" not only encompasses a Health Professional Shortage Area but also rural areas and an area with a demonstrated need for the physician, as determined by the Secretary of the Department of Health and Human Services. In addition, the geographic service area may include an area where at least 75 percent of the physician's patients reside in a medically underserved area or are members of a medically underserved population.

## 7. Mission support payments

Many DHS entities make mission support payments to their affiliates in order to fulfill their missions of medical research, education and healthcare services to the community.

The Stark law provides a safe harbor for those DHS entities that meet the Academic Medical Centers exception. 42 C.F.R. 411.355(e). The AMC

exception is extensive as it is complicated. Each element of the exception must be satisfied when an academic medical center makes mission support payments to a faculty practice or other affiliates. The indirect compensation exception may also be available in those cases where the support arrangement constitutes an indirect compensation as defined by the Stark law. Like the AMC exception, the indirect compensation exception entails a number of elements; each element of the indirect compensation definition and the exception must be satisfied. 42 C.F.R. 411.354(c) (2) and 411.357(p). An indirect compensation relationship may exist when at least one person or entity is interposed between the DHS entity and the referring physician. If the affiliate that is receiving the mission support payment is a physician organization and its physician employee has an ownership or investment interest in the organization, the physician-owner is deemed to stand in the shoes of the organization. As a result, arrangements that were previously treated as indirect would now be direct, and one of the direct compensation exceptions must be satisfied. 42 C.F.R. 411.354(c)(1)(ii).

A DHS entity may avoid the Stark law implications entirely if it has no financial relationship with the physician employees of the affiliate. There is no financial relationship under the Stark law if: (i) a DHS entity provides mission support payments directly to its affiliate; (ii) the affiliate is not owned by any of its physician employees; and (iii) the affiliate's compensation of its physician employees does not take into account the volume or value of referrals or other business generated by the physician employees to the DHS entity. If these three conditions are met, a DHS entity may make payments to its affiliate to keep it in good financial shape and accomplish its missions without implicating the Stark law.

## **8. Publicly-traded company exception**

The Stark law excludes certain ownership interests in a DHS entity from the definition of the financial relationship, including ownership of investment securities that could be purchased on the open market when the DHS referral was made. These securities must either be listed for trading on the NASDAQ or a similar system, or traded under an automated dealer quotation system by the National Association of Securities Dealers. Further, the securities must be in a corporation that had stock holder equity exceeding \$75 million either at the end of the corporation's most recent fiscal year or on average during the previous three fiscal years. 42 C.F.R. 411.356(a). Here, stock holder equity means the excess of the hospital's net assets over its total liabilities.

## **9. Isolated transactions**

Physicians may engage in an isolated financial transaction with a DHS entity without violating the Stark law only if the following conditions are met. First, the amount of remuneration must be based on fair market value and not take into

account the volume or value of any referrals a physician makes to the DHS entity or any other business generated by the parties. Second, the arrangement must be commercially reasonable even if no referrals are made between the parties. Finally, no additional transactions, except ones specifically excepted from the Stark law, may occur for six months after the isolated transaction. 42 C.F.R. 411.357(f). Installment payments may qualify as payment as part of an isolated transaction if the total aggregate payment is: (i) set before the first payment is made; (ii) does not take into account, directly or indirectly, referrals or other business generated by the referring physician; and (iii) is secured. 72 F.R. 51055 (Sept. 5, 2007).

## **10. Non-monetary compensation benefits**

A physician may receive from a DHS entity non-monetary compensations up to \$300 in the aggregate a year (i.e., meals, parking, training, etc.) (This amount is adjusted annually for inflation; the aggregate amount is \$355 for 2009). Non-monetary compensation cannot take into account the volume or value of any referrals or other business generated by the physician. Further, the physician must not have solicited such compensation. The compensation must also not violate the anti-kickback statute or any federal or state law. 42 C.F.R. 411.357(k). CMS recommends that hospitals implement compliance systems, such as mechanisms to track and value the provision of gifts, complimentary items and other benefits for physicians, to ensure non-monetary compensation does not exceed the annual spending limit. 72 F.R. 51058 (Sept. 5, 2007).

The Stark law does allow a hospital with a formal medical staff to throw a local staff appreciation event once a year without adhering to the spending cap. Any gifts or gratuities provided in connection with the event, however, are subject to the spending cap. 42 C.F.R. 411.357(k)(4). Finally, the recent revision to the Stark law now allows an entity to stay below the spending cap when it inadvertently exceeds the cap by no more than 50 percent and the physician repays the excess within that calendar year or 180 consecutive days from receipt of the excess compensation, whichever is earlier. The entity and the physician may rely on the repayment provision no more than once every three years. 42 C.F.R. 411.357(k)(3).

## **11. Splitting profits from ancillary services within a practice**

There are several ways to split profits from DHS within a group practice, so long as the given profit-splitting method is not related to the volume or value of referrals. Two profit-sharing methods that are not prohibited by Stark include certain profit-sharing arrangements between members of a group practice and certain productivity bonuses.

When a physician's group meets the Stark law's definition of a "group practice," its physicians

may receive a share of the overall profits so long as the distribution is reasonable, verifiable and unrelated to the volume or value of referrals. The Stark law deems certain methods of profit sharing as not relating directly to the volume or value of referrals. The profits, for example, may be divided per member of the group. The group may also distribute DHS revenues based on the distribution of the group's revenues attributed to services that are not DHS payable by any federal healthcare program or private payor. Finally, the Stark law allows any method of profit-sharing if DHS revenues constitute less than 5 percent of the group practice's total revenues and no physician's share is more than 5 percent of the physician's total compensation from the group practice. 42 C.F.R. 411.352(i)(1) & (2).

CMS has explicitly stated that "all physicians, whether employees, independent contractors, or academic medical center physicians, can be paid productivity bonuses based on work they personally perform." 69 F.R. 16067 (March 26, 2004). A physician may be paid a productivity bonus based on work personally performed by that physician, so long as the productivity bonus is not calculated in a way that directly relates to the volume or value of a physician's DHS referrals. One such method of calculating productivity bonuses is to base a physician's bonus on his or her total patient encounters or relative value units. 42 C.F.R. 411.352(i)(3). ■

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## 20 Physician Leaders to Know (*continued from page 1*)

Division on Engineering and Physical Science and the National Research Council. Dr. Cortese will be retiring in Nov. 2009.

**Delos M. "Toby" Cosgrove, MD.** Dr. Cosgrove is president and CEO of the Cleveland Clinic Foundation, which is comprised of the Cleveland Clinic, nine community hospitals, 14 family health centers and ASCs, Cleveland Clinic Florida, Cleveland Clinic Toronto and the developing Cleveland Clinic Abu Dhabi. He was named chairman of the Cleveland Clinic's Department of Thoracic and Cardiovascular Surgery in 1989. Dr. Cosgrove has filed 30 patents for developing medical and clinical products used in surgical environments. He is a member of 16 scientific societies including the Society of Thoracic Surgeons, the American College of Surgeons, the American Heart Association and the American Association of Thoracic Surgery, for which he served as president in 2000. He has published nearly 450 journal articles, book chapters, one book and 17 training and CME films.

**Joseph Golbus, MD.** Dr. Golbus is president of the NorthShore University HealthSystem Medical Group and assistant professor of medicine at the Northwestern University Medical School in Evanston, Ill. He earned his medical degree from the University of Illinois Abraham Lincoln School of Medicine. He completed an internal medicine residency at Evanston Hospital and was a fellow in the Rockham Arthritis Research Unit, Division of Rheumatology, at the University of Michigan.

**Larry J. Goodman, MD.** Dr. Goodman is president and CEO of Rush University Medical Center in Chicago. Prior to being named president and CEO, Dr. Goodman was senior vice president for medical affairs at Rush and the Henry R. Russe Dean of Rush Medical College. He is also a professor of medicine at the college. Before accepting the position of senior vice president in 1998, he was medical director of Cook County Hospital. During this time, he also served as professor of medicine and associate dean of Rush Medical College. Dr. Goodman received his medical degree from the University of Michigan Medical School. He completed his residency at Rush University Medical Center in internal medicine and was named chief resident. He completed a fellowship in infectious disease also at Rush.

**Gary L. Gottlieb, MD.** Dr. Gottlieb is president of Brigham and Women's Hospital in Boston. He is also a professor of psychiatry at Harvard Medical School. Dr. Gottlieb also focuses his attention on workforce development and disparities in healthcare. He was appointed by Mayor Thomas Menino as chairman of the city's workforce development board, which partners with education, labor, higher education, the community and government to provide oversight and leadership to public and private workforce development programs. In 2004-2005, he served as co-chair of the Mayor's Task Force to Eliminate Health Disparities. One of Dr. Gottlieb's personal objectives is to improve access to the best possible healthcare for everyone. In 2010, he will succeed James Mongan as president and CEO of Partners Health System in Boston.

**John Koster, MD.** Dr. Koster is president and CEO of Providence Health and Services in Seattle. He previously held primary responsibility for system operations since he joined Providence in 1997. Prior to Providence, Dr. Koster served as vice president for Targeted Member Services at VHA in Irving, Texas, and was vice president of Presbyterian Healthcare Services in Albuquerque, N.M. He was also senior vice president of Rocky Mountain Healthcare Corp. He is board certified in internal medicine and earned his medical degree from the University of New Mexico.

**James L. Madara, MD.** Dr. Madara is CEO of the University of Chicago Medical Center, dean of the Division of Biological Sciences, dean of Pritzker School of Medicine and vice president for Medical Affairs. During his first term, funding for the University from the National Institutes of Health increased by approximately 75 percent. He has overseen significant expansion of clinical and research space at the University, including the opening of Comer Children's Hospital and the Gordon Center for Integrative Science. Previously, he worked at Brigham and Women's Hospital and was director of the Harvard Digestive Diseases Center. He has published considerable research on the cells that line the digestive tract and how these cells permit the absorption of nutrients while serving as a barrier to intestinal bacteria and help regulate the immune response to normal and disease-causing bacteria. This research has been crucial to understanding infectious diseases that affect the intestine, to treating inflammatory disorders such as ulcerative colitis or Crohn's disease, and to improving drug delivery.

**Stephen Newman, MD.** Dr. Newman is COO and interim chief medical officer of Tenet Healthcare Corp., in Dallas, Texas. He is responsible for the operational oversight of Tenet's 52 acute care hospitals in 12 states, as well as ASCs and diagnostic imaging centers. He previously served as CEO for Tenet's California operations and implemented the company's Targeted Growth Initiative, which matched a hospital's current service offerings and growth plans against the future needs of its community. Prior to becoming a hospital administrator, Dr. Newman was a pediatric gastroenterologist for 12 years and was a professor of pediatrics and medicine at Wright State University School of Medicine in Dayton, Ohio, and was director of gastroenterology and nutrition support at Children's Medical Center. He also serves on the board of directors of the Federation of American Hospitals.

**Nancy H. Nielsen, MD, PhD.** Dr. Nielsen is president of the American Medical Association and is a clinical professor of medicine and senior associate dean for medical education at the State University of New York at Buffalo School of Medicine and Biomedical Sciences. She was speaker of the AMA House of Delegates, a delegate from New York and previously served two terms on the AMA Council on Scientific Affairs. Dr. Nielsen has served as a member of the National Patient Safety Foundation Board of Directors, the Commission for the Prevention of Youth Violence and the Task Force on Quality and Patient Safety. She is the AMA representative on many quality initiatives, including the National Quality Forum, the AMA Physician Consortium for Performance Improvement, the Ambulatory Care Quality Alliance and the Quality Alliance Steering Committee. She serves on the Institute of Medicine's Roundtable on Evidence-Based Medicine. Dr. Nielsen was speaker of the Medical Society of the State of New York House of Delegates and a member of the board of direc-

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Here are the 2008 median base salaries for hospital and health system CEOs and CFOs, according to the Integrated Healthcare Strategies 2008 *Healthcare Executive Compensation Survey*.

### Health system

CEO — \$622,300  
CFO — \$365,000

### Hospital

CEO — \$490,000  
CFO — \$271,100

*Source:* Integrated Healthcare Strategies 2008 *Healthcare Executive Compensation Survey*.

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tors of the Medical Liability Mutual Insurance Company. She also was president of her county medical society and her hospital's medical staff. Dr. Nielsen holds a doctorate in microbiology and received her medical degree from SUNY at Buffalo School of Medicine and Biomedical Sciences. She was a member of the board of directors of Kaleida Health — a five-hospital system in western New York — and was chief medical officer of a large regional health plan in the Buffalo area.

**Herbert Pardes, MD.** Dr. Pardes is president and CEO of the New York Presbyterian Health Care System in New York, N.Y. He served as U.S. Assistant Surgeon General and was director of the National Institutes of Mental Health during the Carter and Reagan Administrations. He served as vice president for health sciences at Columbia University and dean of the faculty of medicine of Columbia's College of Physicians and Surgeons, positions he held while he was chairman of Columbia's Department of Psychiatry. He was the director of the Psychiatry Service at the Presbyterian Hospital and director of the New York State Psychiatric Institute. He served as chairman of the Association of American Medical Colleges and the AAMC's Council of Deans. He served two terms as chairman of the New York Association of Medical Schools. In 1997, he was elected to the Institute of Medicine of the National Academy of Sciences. Dr. Pardes has served as chairman of the psychiatry departments at the State University of New York, Downstate, the University of Colorado Medical Center and Columbia. He served as president of the American Psychiatric Association for 1989-90 and as chairman of the APA's Council on Research. In 1986, he served as chairman of the Association of Chairmen of Departments of Psychiatry.

**Patrick J. Quinlan, MD.** Dr. Quinlan is CEO of Ochsner Health System in New Orleans and is responsible for all operations and strategic growth. He previously served as chief medical officer for Ochsner and was chief medical officer at Lovelace Health Systems in Albuquerque, N.M. Dr. Quinlan earned his BA in economics from the University of Texas at Austin and his medical degree from the University of Texas Medical Branch at Galveston. He completed his internship at Carraway Methodist Center in Birmingham, Ala., and a dermatology residency at the University of Alabama at Birmingham and is board certified in Dermatology. He earned a master's degree in health administration from the College of St. Francis in Albuquerque.

**Prem Reddy, MD, FACC, FACP.** Dr. Reddy is chairman and founder of Prime Healthcare Services in Victorville, Calif., which oversees 13 hospitals and three medical groups. He is board certified in both internal medicine and cardiology. During his 25 years serving the High Desert region of California, he has built several prac-

tices and hospitals from the ground up, including the Desert Valley Medical Group and Desert Valley Hospital. He is a fellow of the American College of Cardiologists and the American College of Physicians. Dr. Reddy is committed to serving his community and founded the Dr. Prem Reddy Family Fund, which is a nonprofit organization that serves the healthcare needs of the High Desert community, including a free public health library, a scholarship fund and support of other healthcare-related charities. In addition, Dr. Reddy is an active philanthropist and supports education and social services, donating time and money to both of these causes.

**William Roper, MD, MPH.** Dr. Roper is CEO and vice chancellor of medical affairs for the University of North Carolina Health Care System in Chapel Hill, N.C., and dean of the UNC School of Medicine. He also is professor of health policy and administration in the School of Public Health and is professor of pediatrics in the School of Medicine at UNC. Prior to joining UNC, Dr. Roper was vice president of Prudential HealthCare, director of the CDC, served on the senior White House staff and was administrator of the Health Care Financing Administration (responsible for Medicare and Medicaid), and was a White House fellow. Dr. Roper is a member of the Institute of Medicine of the National Academy of Sciences and a member of the board of trustees of the Robert Wood Johnson Foundation. He is a member of the board of directors of DaVita and Delhaize Group and is a member of the President's Commission on White House Fellowships and the chairman of the board of directors of

the National Quality Forum. Dr. Roper offers his advice and opinions on topics related to healthcare through his blog, *Roper on Health*.

**Thomas Royer, MD.** Dr. Royer is CEO and president of the CHRISTUS Health System in Irving, Texas, and leads day-to-day operations for CHRISTUS Health, lending extensive expertise in developing physician partnerships and community health programs within the company. Before joining CHRISTUS, Dr. Royer served as senior vice president of medical affairs and chairman of the board of governors of Henry Ford Medical Group. He served for two years at Johns Hopkins Medical Services Corporation and Wyman Park Medical Associates in Baltimore in a variety of positions, including CEO, president and COO and vice president of clinical operations. Dr. Royer, who is board certified in surgery, received his medical degree from the University of Pennsylvania and completed his postdoctoral training at Geisinger Medical Center and Clinic.

**David Shulkin, MD.** Dr. Shulkin is president and CEO of Beth Israel Medical Center in New York, N.Y. He previously served in numerous physician leadership roles including the chief medical officer of the University of Pennsylvania Health System, the Hospital of the University of Pennsylvania, Temple University Hospital and the Medical College of Pennsylvania Hospital and was the chairman of medicine and vice dean at Drexel University School of Medicine. Dr. Shulkin founded and served as the chairman and CEO of DoctorQuality, one of the first consumer-orientated sources of information for quality and safety in healthcare. He has served on the editorial boards of numerous journals

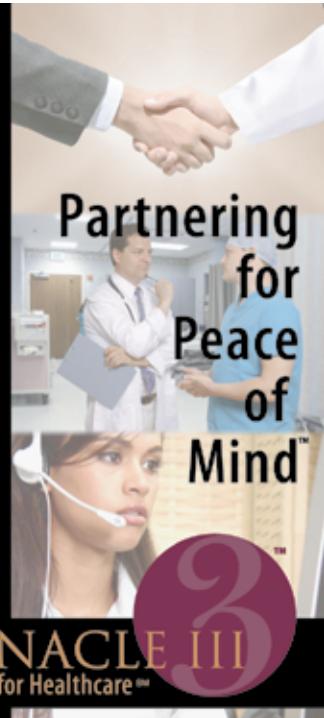
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including the *Journal of the American Medical Association*. Dr. Shulkin recently published a book, *Questions Patients Need to Ask*, to better educate and empower patients.

**Kendall L. Stewart, MD.** Dr. Stewart is vice president of medical affairs and chief medical officer of Southern Ohio Medical Center and the president and CEO of SOMC Medical Care Foundation in Portsmouth, Ohio. He is a past president of the Ohio Psychiatric Association and teaches psychiatry at the Ohio University College of Osteopathic Medicine in Athens, Ohio. He also practices general adult psychiatry. Dr. Stewart has served on the boards of the Medical Group of Ohio, OhioHealth Group and the Ohio Partnership for Excellence. He completed his medical and psychiatric training at the Medical College of Georgia. He served as chief of the Mental Health Clinic at Ellsworth Air Force Base near Rapid City, S.D., before opening his private practice in Portsmouth. He completed his MBA at Ohio University.

"Dr. Stewart has done extensive work in molding physician behavior and managing misbehavior in a respectful manner," says Carol Fairchild, vice president of operations for the Ambulatory Surgical Centers of America. He is also the author of *A Portable Memoir for Organizational Leaders*.

**Paul Summerside, MD, FAAEM, FACEP.** Dr. Summerside is the chief medical officer of BayCare Clinic and president of Aurora BayCare Medical Center, both located in Green Bay, Wisc. He is also director of wellness at BayCare Sports Medicine and chairman of medical education at the University of Wisconsin affiliated Medical School program in Green Bay. He is a member of the BayCare Clinic Board and Executive Committee. Prior to arriving at BayCare, Dr. Summerside maintained an emergency med-

icine practice. He is an active member of the American College of Physician Executives. He received his medical degree from the University of Iowa College of Medicine and completed his residency in emergency medicine at the University of Illinois. Dr. Summerside received his master's of medical management from the University of Southern California and is a fellow of the American Academy of Emergency Medicine. He is an active member and current president of the De Pere (Wisc.) School Board.

**Nick Turkal, MD.** Dr. Turkal is president and CEO of Aurora Health Care in Milwaukee, Wisc. Prior to becoming CEO, he was senior vice president and president of the company's Metro Region. He was the former St. Luke's program director and family medicine associate chair. Dr. Turkal grew up in Nebraska and graduated from Creighton University Medical School before coming to Milwaukee for residency training at St. Michael's Family Practice Residency Program. He ran a solo practice in Robinson, Ill., before coming to St. Luke's in 1989.

**Harold Varmus, MD.** Dr. Varmus is president and CEO of Memorial Sloan-Kettering Cancer Center in New York, N.Y. He was the former director of the National Institutes of Health and co-recipient (along with Dr. J. Michael Bishop) of a Nobel Prize for studies of the genetic basis of cancer. While at MSKCC, he aimed to harness recent advances in the biological sciences to improve the care of patients with cancer. In addition, the scientific programs have been reorganized and enlarged, and he has overseen the construction of several new facilities. While at the NIH, Dr. Varmus initiated many changes in the conduct of intramural and extramural research programs, recruited new leaders for most of the important positions at the NIH, planned

three major buildings on the NIH campus and helped to initiate the five-year doubling of the NIH budget. He has authored more than 300 scientific papers and four books, including an introduction to the genetic basis of cancer for a general audience, and he has been an advisor to the federal government, pharmaceutical and biotechnology firms and many academic institutions. He served on the World Health Organization's Commission on Macroeconomics and Health and is a co-founder and chairman of the board of directors of the Public Library of Science. He chairs the scientific board of the Grand Challenges in Global Health at the Bill and Melinda Gates Foundation and is involved in initiatives to promote science in developing countries, including the Global Science Corps, through the Science Initiatives Group.

**Paul Whelton, MD, MSc.** Dr. Whelton is president and CEO of Loyola University Health System in Chicago. He was senior vice president for health sciences at Tulane University Health Sciences Center and was dean of the Tulane University School of Medicine. Dr. Whelton has held faculty positions at both Tulane and Johns Hopkins University. A native of Cork City, Ireland, Dr. Whelton received his medical degree from the National University of Ireland, University College Cork and a master of science degree in epidemiology from the University of London School of Hygiene and Tropical Medicine. Dr. Whelton has conducted a series of groundbreaking studies on the prevention and treatment of hypertension for the National Heart, Lung and Blood Institute, the National Institute of Diabetes and Digestive and Kidney Diseases and the National Institute on Aging. He is well published and has served as a consultant to numerous national and international health agencies and governments. ■

## Coming up in the July issue of *The Hospital Review*:

- Practical Guidance for Developing a Successful Hospital Orthopedics Program
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# Despite Rate Changes, Oncology Still Profitable: Hospitals Respond To Evolving Market Dynamics

By Mark Taylor

**C**ancer treatment is evolving rapidly, which presents both opportunities and challenges to hospitals seeking to maintain or expand their oncology services. Healthcare experts say cancer treatment, spurred by improvements in technology, better drugs and reimbursement changes, is increasingly leaving hospitals for physician offices and ASCs. That could represent lost revenue to many hospitals and health systems. At the same time, oncology delivery experts see many factors favoring hospitals in this volatile market.

"Cancer treatment delivery is a dynamic area and we're seeing some pretty vast changes," says Christian Downs, executive director of the Association of Community Cancer Centers, the Rockville, Md., an organization representing more than 700 institutions treating 45 percent of all U.S. cancer patients. "A lot of the care now is becoming more sophisticated. Twenty to 30 years ago, most cancer care was delivered in hospitals. In the last five years much of that has left hospitals for outpatient settings."

The introduction of orally-administered cancer drugs that can be taken at home is expanding delivery options even further. Mr. Downs says reimbursement for in-patient cancer care began to decline significantly in the mid-1980s. "We're now seeing reductions in hospital outpatient settings, too, which could push more patients to physician office settings."

However, Mr. Downs says hospitals will continue to play a vital role in cancer treatment.

"You have to remember the reason people are getting treated," he says. "Cancer is a difficult disease and many patients aren't going out of the hospital. A lot is still being done in hospitals. In most markets, the hospital is still the one to handle the surgeries and linear accelerators and the diagnostic equipment. It's still a revenue source for many of them."

"We're seeing hospitals grow their cancer services," Mr. Downs says. "Cancer does provide a high-tech payload to hospitals. Many employers and insurance plans want to see a good cancer program in their network."

He says not many cancer programs have empty waiting rooms.

"When programs don't succeed, it's usually because of weak management or lack of commitment by the institution and not just economics," he says. "We are seeing joint-ventures between doctors and

hospitals to leverage each other's strengths. We're not seeing an exodus from hospitals, they're not closing down facilities. I'm seeing programs expanding and making a larger commitment to their cancer programs. They're trying to do what best fits their community needs and adapt their strengths to that model. We're seeing physician employee models, large, multi-disciplinary group contracts with hospital and community hospitals affiliating with large, academic medical centers"

## Developing successful programs requires multifaceted approach

Mr. Downs says he's seeing more hospitals and physician offices using oncology pharmacists, taking advantage of their clinical and economic skills. And they're doing much more clinical evaluation, make suggestions to providers and helping them to become smarter purchasers of drugs. The downside, he says, is it's difficult to find board-certified oncology pharmacists.

He says hospitals need to make an institutional commitment to their oncology programs. "I'm amazed by the number of CEOs who don't," he says. "It's not just resources, but the CEOs and leadership must be invested in giving time, resources and priority, a real commitment beyond the money to make sure it's successful."

He predicts that oncology programs will soon see greater benchmarking. "Right now more work needs to be done on that," he acknowledges.

Ernest Anderson, director of pharmacy for the Burlington, Mass.-based Lahey Clinic and ACCC's current president, says many hospitals are actually expanding their oncology programs.

"While reimbursement on the drug side is a problem, overall cancer treatment remains a profitable venture for hospitals, albeit not as lucrative as it used to be," Mr. Anderson says.

## Oncology opportunities aplenty

He sees plenty of competition for oncology care in his native New England, but less in rural, less-populated areas. "The Medicare side of reimbursement has deteriorated and some physicians would rather shuttle Medicare patients to hospitals and keep the commercial insurance patients in their offices," he says. "And if they can do that, they will, but it won't be a good thing for hospitals."

Janet Nelson, an oncology nurse, practice consul-

tant and executive with several oncology firms, says there are opportunities for hospitals to create good oncology programs to meet market needs.

"But the model has shifted in reimbursement and they need to look at different ways to recapture oncology revenues," says Ms. Nelson, now the chief operating officer of Dallas-based Next-Gen Oncology. "With many physician-hospital owned ASCs facing unwinding, there are many opportunities for hospitals."

She points out that in Oct. 2009, physician-hospital joint venture ASCs will no longer be allowed to bill under-arrangement under the higher reimbursement hospital provider number.

Ms. Nelson says there are other opportunities for hospitals to invest in technology and recruit disease specialist physicians to grow their business lines in breast treatment, radiation therapy and pharmacy to regain market share.

She says the majority of radiation oncology centers are still owned by hospitals because they typically have deeper pockets and the technology is prohibitively expensive. She says recent changes in Medicare reimbursement are costing physicians money.

"We're seeing many hospitals buying oncology physician practices," she says.

She says large academic medical centers known for cancer treatment, M.D. Anderson and Sloan Kettering, for example, are fully-integrated healthcare systems with faculty physicians who teach and perform research and attract public dollars and capital.

"If they have a good business sense, they can compete in the marketplace," she says. She says most of the revenue in oncology comes from surgery and radiation, "two cash cows" remaining in the oncology space allowing community hospitals solid opportunities to compete for business.

Ms. Nelson says physicians are scrambling like community hospitals to figure out a model for survival and are seeking partnering opportunities. Many cancer specialists are joining large, multi-disciplinary practices or selling their own practices to hospitals.

"It's hard to predict, given the current reimbursement climate, which model is likely to succeed," she says. ■

Contact Mark Taylor at [mark@beckersasi.com](mailto:mark@beckersasi.com).

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- Managed Care Negotiation Strategies for Orthopedic and Spine Driven Centers
- Uni Knees in the Outpatient Setting – Is This the Right Fit for Your ASC? Clinical and Financial Issues
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- How to Recruit and Retain Great Administrators and Directors of Nursing
- Handling Complex Spine Cases in an ASC, High Level Fusion and 23-Hour Cases
- Key Strategies for Controlling Implant Costs in ASCs and Surgical Hospitals
- New Trends in Ambulatory Spine Surgery
- Physician Owned Hospitals – Key Concepts to Increase Profits
- The Evolution of Healthcare and the Impact on ASCs
- Orthopedics – The Forecast for the Next Five Years
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## CONFERENCE PROGRAM

### THURSDAY, JUNE 11, 2009

**12:00 – 1:30 pm – Registration**

**12:00 – 4:30 pm – Exhibitor Setup**

**Pre-Conference Workshop – Concurrent Sessions A, B, C, D, E**  
**1:30 – 2:30 pm**

**A. Developing a Highly Successful Orthopedic-Driven ASC**

*Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America; and Tom Mead, M.D., Surgery Center of Allentown*

**B. Using Orthopedics and Spine to Turn Around an ASC**

*Tom Mallon, CEO, and Jeff Simmons, President Western Division, Regent Surgical Health*

**C. Sequencing an Orthopedic Start-Up ASC – Tactics for New and Ramp-Up ASCs to Optimize Their Operations**

*Larry Taylor, President and CEO, Practice Partners in Healthcare*

**D1. (1:30 – 2:00 pm) Valuing ASCs for Syndication - A Presentation of Current Market Multiples and Question and Answer**

*Greg Koonsman, Principal, and Jon O'Sullivan, Principal, VMG Health*

**D2. (2:00 – 2:30 pm) The Impact of the Financing Market on Valuations**

*Jon O'Sullivan, Principal, VMG Health; Doug Lewis, Managing Director and Shannon LeRoy, CEO and Managing Director, Physicians Capital*

**E. A Year Later – The Successful Turnaround of a Failing Hospital-Physician Joint Venture ASC**

*George Trajtenberg, M.D., Mark Beaugard, M.D., and Lisa Shriner, Administrator, Turks Head Surgery Center*

**2:30 – 3:20 pm**

**A. Managed Care Negotiation Strategies for Orthopedic and Spine-Driven Centers**

*Naya Kehayes, CEO, Eveia Health Consulting and Management*

**B. Uni Knees in the Outpatient Setting – Is This the Right Fit for Your ASC? Clinical and Financial Issues**

*Blaine Farless, M.D., and James McGeehee, RN, Administrator, Cleburne Surgical Center; and Sarah Martin, RVP of Operations, Meridian Surgical Partners*

**C. Physician-Owned Hospitals - Key Factors for Success and Core Challenges**

*Molly Sandvig, Executive Director, Physician Hospitals of America; John Thomas, EVP, HC REIT; and John Rex-Waller, CEO, National Surgical Hospitals*

**D. Are Stark and Self Referral Laws Going to Close Down ASCs and Physician Owned Hospitals?**

*Scott Becker, JD, CPA, Partner, and Amber Walsh, JD, McGuireWoods LLP*

**E. Spine ASC – An Important Element in a Health System's Spine Center of Excellence**

*Jeff Leland, Managing Director, Blue Chip Surgical Center Partners*

**3:20 – 4:10 pm**

**A. How to Recruit and Retain Great Administrators and Directors of Nursing**

*Greg Zoch, Partner, Kaye Bassman*

**B. A Case Study and Strategies to Achieve Excellent Results for an ASC**

*Kenneth Austin, M.D., Ramapo Valley Surgery Center; and Bob Zasa, Founder, Woodrum ASD*

**C. Handling Complex Spine Cases in an ASC, High Level Fusion and 23 Hour Cases**

*John Seitz, CEO, Ambulatory Surgical Group*

**D. Key Strategies for Controlling Implant Costs in ASCs and Surgical Hospitals**

*Randi Pisko, CEO, North Carolina Specialty Hospital; and Richard F. Bruch, M.D., Triangle Orthopaedic Associates*

**E. The Acceleration of Physician-Hospitals Collaboration – Trends and Strategies**

*Bill Woodson, SVP, Sg2; Tom Stallings, Partner, Kristian Werling, JD, and Elissa Moore, JD, McGuireWoods LLP*

**4:15 – 5:00 pm**

**A. Physician Recruitment in 2009 – Some Key Thoughts and Challenges on Recruiting Orthopedics Neurosurgeons and Pain Management Physicians**

*Kenny Spitler, SVP Development, HealthMark Partners*

### THURSDAY, JUNE 11, 2009

**B. New Trends in Ambulatory Spine Surgery**

*David Abraham, M.D., Reading Neck and Spine Center*

**C. Ten Keys to Improving Billing and Collections in a Challenging Economy**

*Carol Serbin, CEO, Serbin Surgical Center Billing*

**D. Healthcare Valuations – Current Trends and Perspectives in Majority Interest Valuations**

*Todd Mello, Principal and Co-Founder, Healthcare Appraisers*

**E. Physician Owned Hospitals – Key Concepts to Increase Profits**

*Tom Michaud, CEO, Foundation Surgery Affiliates*

**5:00 – 7:00 pm – Networking Reception & Exhibits**

### FRIDAY, JUNE 12, 2009

**7:00 – 8:00 am – Registration and Continental Breakfast**

**Main Conference – General Session**

**8:00 am**

**Introductions**

*Scott Becker, JD, CPA, Partner, McGuireWoods LLP*

**8:00 – 8:55 am**

**The Evolution of Healthcare and the Impact on ASCs**

*Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University*

**9:00 – 9:40 am**

**Orthopedics – The Forecast for the Next Five Years**

*John Cherf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago*

**9:45 – 10:20 am**

**Using Spine as the Backbone of a Multi-Specialty ASC**

*James Lynch, M.D., Surgery Center of Reno*

**10:20 – 11:20 am – Hall Break**

**11:20 – 11:55 am**

**7 Steps to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy**

*Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America*

**12:00 – 12:30 pm**

**Case Study – Two Years Later, A Physician-Owned Spine ASC – A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems**

*John Caruso, M.D., Parkway Surgery Center, Hagerstown, Maryland*

**12:30 – 1:30 pm – Networking Lunch & Exhibits**

**Concurrent Sessions A, B, C, D, E**

**1:30 – 2:05 pm**

**A. A Payor's View of Orthopedics, Spine and Pain Management**

*Steven Stern, M.D., VP Neuroscience, Orthopedics and Spine, United Healthcare*

**B. Spine Centers – A Case Study Review of Current Outcomes and Issues**

*Marcus Williamson, M.D., and George Goodwin, SVP and Chief Development Officer, Symbion Healthcare*

**C. Making Big Cases Profitable in an ASC**

*Naya Kehayes, CEO, Eveia Health Consulting; and Greg Canniff, CFO, National Surgical Care*

**D. Capturing Your Partners' Cases, The Carrot and Stick Approach**

*Chris Bishop, VP, Ambulatory Surgical Centers of America*

**E. Key Legal Issues – Safe Harbor Compliance, Out of Network, and Other Legal Issues**

*Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods LLP*

**2:10 – 2:45 pm**

**A. Hand Surgery in ASCs – Key Concepts for Success**

*Ed Rudisill, M.D., The Hand Center, Greenville, SC*

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## CONFERENCE PROGRAM

### FRIDAY, JUNE 12, 2009

#### B. Pain Management in ASCs - Current Methods to Increase Profits

Amy Mowles, President & CEO, Mowles Medical Practice Management

#### C. 5 Tips for Managing Anesthesia in Your ASC

Thomas Yerden, CEO and Founder, TRY HealthCare Solutions

#### D. How to Recruit Great Surgeons to Work at Your ASC

Robert Carrera, President, Pinnacle III

#### E. Turnarounds – 2 Case Studies – 5 Key Ideas for Success

Joe Zasa, President, Woodrum ASD

2:45 – 3:45 pm – Exhibits Open

3:45 – 4:20 pm

#### A. How Much is Your ASC Worth? What Terms Can You Expect? What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away

Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

#### B. Is Your Center too Dependent on a Single Specialty? How to Diversify and Make Change Happen

John Seitz, CEO, Ambulatory Surgical Group; Joe Zasa, CEO, Woodrum ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare

#### C. 5 Core Concepts for Great ASC Joint Ventures with Hospital Partners

Mike Pankey, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing

#### D. Assessing the Profitability of Orthopedics, Spine and Pain in ASCS

Luke Lambert, CEO, Ambulatory Surgery Centers of America

#### E. 5 Core Strategies to Immediately Improve ASC and Hospital Operations

Doug Johnson, COO, RMC MedStone Capital

4:20 – 4:55 pm

#### A. How Much is Your ASC Worth? What Terms Can You Expect? What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away (continued)

Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

#### B. Ulnar Collateral Ligament Reconstruction: "The Tommy John Surgery"

Timothy Kremchek, M.D., Medical Director, Cincinnati Reds; Larry Taylor, President and CEO, Practice Partners in Healthcare

#### C. The Development & Integration of Orthopedics into a Multi-Specialty ASC

William Jacobson, M.D., President, West Lakes Surgery Center; Rob McCarville, Principal, Medical Consulting Group; and John Marasco, Principal and Owner, Marasco and Associates

#### D. 2 Key Issues: Working with Implant Brokers and Out-of-Network Issues

Dan Connolly, Vice President, Pinnacle III

#### E. Turnarounds – Lessons of the Last Five Years – Expectations of the Next Five Years

Bill Southwick, President and CEO, HealthMark Partners

4:55 – 5:30 pm

#### A. Orthopedics in ASCs – What Works and What Doesn't From a Business and Clinical Perspective

John Cherf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago

#### B. Physician Owned Hospitals – What Should You Do Now?

Ajay Mangal, M.D., CEO, Prexus Health; and Brett Gosney, CEO, Animas Surgical Hospital

#### C. How to Work Successfully with Generation Y

Lt. Colonel Bruce Bright, Director of Business Development, The Sanders Trust

#### D. The 5 Best Ways to Improve Billings and Collections and to Improve Revenue Cycle Management

Lisa Rock, President, National Medical Billing Services; and David Hamilton, President & CEO, MNET Collections

#### E. Common Litigation Issues in ASCs – Antitrust, Non Competes and More

Jeff Clark, Partner, and Richard Greenberg, Partner, McGuireWoods LLP

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5:30 – 7:00 pm – Networking Reception & Exhibits

### SATURDAY, JUNE 13, 2009

7:30 – 8:15 am – Continental Breakfast

8:15 – 9:00 am

#### How Economic Conditions Impact Health Care Strategies for Success

Tom Geiser, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates

9:05 – 9:50 am

#### A. Uni Knees and Shoulders in the Outpatient Setting – Cost, Staffing and Profitability Issues

Peter Kurzweil, M.D. and Margarita de Jesus, Administrator, Surgery Center of Long Beach

#### B. Key Issues Faced by ASCs Today

Thomas Yerden, CEO, Founder, TRY HealthCare Solutions

#### C. The Pros and Cons of Total Knees in a 23-Hour Setting – Financial and Safety Issues

Eric Monesmith, M.D., OrthoIndy; and John Martin, CEO, OrthoIndy

#### D. Pain Management – 5 Keys to a Superior Pain Management Program Surgery Center

Lance Lehmann, M.D., Medical Director and Liliana Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center

#### E. Implant Costs: Why Facility-Physician Collaboration Makes Sense

Karen Barrow, SVP Business Development, Amerinet

9:55 – 10:35 am

#### A. Key Concepts to Managing an Effective Interventional Pain Management Practice and Center

Lax Manchikanti, M.D.

#### B. An Analysis of Clinical Outcomes for Spine – Procedures Performed in ASCs

Ken Pettine, M.D., Rocky Mountain Surgery Center

#### C. Making the Best Use of An ASCs IT System

Jeff Blankinship, President, Surgical Notes

#### D. Tracking and Improving Patient Satisfaction and How to Apply the Measures to Improve Results

Paul Faracis, President and CEO, CTQ Solutions

10:40 – 11:20 am

#### A. The 10 Statistics Your ASC Should Examine Each Week

Shannon Blakeley, VP Operations, National Surgical Care

#### B. 7 Keys to Successful Physician Hospital Joint Ventures

Edward Herick, President and CEO, Facility Development and Management; and Christian Ellison, VP, Health Inventures

#### C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain-Driven ASCs – Strategies You Can Use Monday Morning

Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America

#### D. 2009 Pain Management Coding Update and Pain Industry Business Trends

Linda Van Horn, MBA

11:25 am – 12:05 pm

#### A. Buying and Selling ASCs – 5 Key Concepts

Scott Becker, JD, CPA, Partner and Scott Downing, Partner, McGuireWoods LLP

#### B. Cost Justifying an EHR, What Is The ROI?

Todd Logan, Regional VP, Source Medical; Daren Smith, Administrator, Fremont Surgical Center

#### C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain Driven ASCs – Strategies You Can use Monday Morning (continued)

Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America

#### D. 10 Keys to Improve Coding for Orthopedic, Spine and Pain in ASCs

Christina Bentin, Founder, Coding Compliance Management

12:10 – 1:00 pm

#### Legal Q & A; Safe Harbors; War and Peace with Hospitals

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

1:00 pm – Meeting Adjourns

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# 11 Hospitals With Great Oncology Programs

By Ariel Levine and René Tomacanin

**A**ccording to Derek Raghavan, MD, director of the Taussig Cancer Institute in Cleveland, “a top cancer center needs to have a fusion of its clinical programs with its experimental and social support programs.” It takes physicians, researchers and staff working together to provide quality patient care in oncology and to create a successful program.

“Sometimes, a brilliant idea in the lab can be translated into great patient benefit in the clinic,” says Dr. Raghavan. “Social support programs ... are also critically important in helping patients negotiate the complex course of fighting cancer. Of course, it is also tremendously important to provide high-quality education — both to cancer specialists and other physicians but also [to] our patients and their supporters.”

Collaboration and education are two of the attributes most commonly associated with successful oncology programs. Here are 11 hospitals with oncology programs that are strong in these areas and many others.

**1. The Cleveland Clinic (Cleveland).** The Cleveland Clinic’s Taussig Cancer Institute is recognized by *U.S. News & World Report* as one of the top cancer hospitals in the country and was ranked first in Ohio in 2008. The Cleveland Clinic sponsors extensive cancer research, which has led to the identification of new molecules with anti-tumor effects. In addition, the hospital has engendered collaborative ties with biotechnology companies, trained younger scientists and expanded their base of financial support.

Dr. Raghavan attributes much of the center’s success to a combination of quality medical practice and creative cancer research. “One of the strengths of the clinic,” he says, “is [that] we identify problems in our practice, [then] go to the lab and figure them out. We not only do good clinical work, but [we] also know how to integrate it with our scientific and laboratory programs.”

Collaboration is another element that makes the Taussig Center successful, according to Dr. Raghavan. The center has partnered with Leukemia and Lymphoma Society in order to develop investigational tools to use in the community. The Taussig Center has also entered into an interactive research relationship with Case Western University. The Cleveland Clinic is involved in the community and maintains programs that help “underserved” patients, such as the elderly.

Education is the final element that Dr. Raghavan says accounts for the center’s success. He says, “We have large training programs in medical/hematologic oncology and in radiation oncology, and one of the largest in the United States in palliative care.” [www.clevelandclinic.org](http://www.clevelandclinic.org)

**2. Fox Chase Cancer Center (Philadelphia).** Fox Chase Cancer Center is an independent, nonprofit institution formed in 1974 by the union of American Oncologic Hospital and the Institute for Cancer Research. The center is comprised of several departments including advanced practice clinicians, anesthesiology, diagnostic imaging and medical oncology, and treats various conditions from brain cancer to melanoma. Fox Chase uses advanced technologies including precise image-guided radiation therapy and intensity-modulated radiotherapy as well as minimally invasive robotic surgery in its treatment of cancer.

Approximately 170 clinical trials of new prevention, diagnostic and treatment techniques are underway at any one time in its research department. In fact, two Fox Chase scientists, Baruch Blumberg and Irwin Rose, have won Nobel Prizes (Mr. Blumberg in Medicine and Mr. Rose in Chemistry) and remain active members within the center. Fox Chase has fellowships in breast cancer, hematology/oncology, pathology and surgical oncology. Fox

Chase also provides screening and education programs for communities in the Philadelphia area. [www.fccc.edu](http://www.fccc.edu)

**3. Dana-Farber Cancer Institute (Boston).** Dana-Farber specializes exclusively in cancer research and care. Partnered with Brigham Women’s Hospital and The Children’s Hospital in Boston, the Dana-Farber provides patients with a complete system of integrated care and treats everything from breast to endocrine to head and neck cancer. The institute has a multidisciplinary team of cancer experts, and patients have access to clinical research trials that offer promising new treatments. Dana-Farber’s physician-researchers are involved in significant research and recently helped to develop Gleevec for the treatment of chronic myeloid leukemia and gastrointestinal stromal tumors. The institute offers a wide range of support services for its adult and pediatric patients, ranging from concerns about death and dying to finding temporary housing.

In 1981, Dana-Farber established the weekly seminar series titled “Seminars in Oncology.” A committee that includes faculty, fellows and students selects the topics and speakers for this series. The seminars draw an audience from the entire Boston biomedical research community. [www.dana-farber.org](http://www.dana-farber.org)

**4. The Hospital of the University of Pennsylvania (Philadelphia).** The Abramson Cancer Center of the University of Pennsylvania has been designated as a comprehensive cancer center by the National Cancer Institute. The center is comprised of 300 physicians and scientists who are dedicated to increasing knowledge about cancer prevention and cures. The center focuses on endocrine and surgical oncology, gynecological oncology and hematology-oncology.

The Hospital of the University of Pennsylvania’s cancer rehabilitation program helps patients handle the results of cancer or cancer treatment, including deconditioning, lymphedema, loss of physical function, neurological deficits, and pain- and cancer-related fatigue. The program offers consultations with a cancer physiatrist and examination services as well as physical therapy services. The cancer physicians work as part of interdisciplinary teams that include experts from various specialties, experienced in diagnosing and treating patients with a particular type of cancer. [www.pennhealth.com](http://www.pennhealth.com)

**5. The Johns Hopkins Hospital (Baltimore).** The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins has been ranked the third best in the nation and the top cancer hospital in the Mid-Atlantic Region by *U.S. News & World Report*. It has also been designated by the NCI as a comprehensive cancer center. The center has active programs in clinical research, laboratory research, education, community outreach and prevention and control.

The center provides a wide range of specialty programs for children and adults, including bone marrow transplantation and new drug development. According to Amy Mone, director of public affairs, patients who visit the Kimmel Cancer Center are able to quickly access new and innovative therapies. Scientists and clinicians at Sidney Kimmel work together, allowing developments in the laboratory to transfer quickly into use in the clinical setting. Information on genetic counseling, early detection and prevention is available through the genetics service for those patients who may be at high risk for breast, ovarian, colon and other cancers. In addition, the Sidney Kimmel offers family and patient services recently opened a 39-suite pavilion for out-of-town patients to stay in while they receive treatment.

Martin Abeloff, MD, considers the successes of the past three decades to be the foundation of the excellent treatment and research taking place at Sidney Kimmel today. “In 1973, we helped define the field of oncology,” he

says. "Today, we are helping to redefine it." [www.hopkinsmedicine.org](http://www.hopkinsmedicine.org)

**6. Memorial Sloan-Kettering Cancer Center (New York City).** Each year, the Memorial Sloan-Kettering Cancer Center treats more than 400 different subtypes of cancer. Its disease management program features 16 multidisciplinary cancer teams. Investigators at Sloan-Kettering collaborate with Memorial Hospital physician-scientists in a process known as "translational research" and have initiated and participated in clinical trials to identify more effective cancer therapies. Currently, they are leading more than 400 clinical trials for pediatric and adult cancers.

In 2004, Sloan-Kettering established a doctoral program in cancer biology through its new Louis V. Gerstner, Jr. Graduate School of Biomedical Sciences. In this program, basic laboratory scientists can earn a PhD and are trained to work in research areas directly relevant to cancer and other human diseases. Sloan-Kettering also offers post-graduate clinical fellowships to train physicians who seek special expertise in a particular type of cancer and postgraduate research fellowships that provide physicians and scientists with advanced laboratory research training. [www.mskcc.org](http://www.mskcc.org)

**7. Ronald Reagan UCLA Medical Center (Los Angeles).** The Ronald Reagan UCLA Medical Center was rated the "Best in the West" for its 19th consecutive year by *U.S. News & World Report*. The hospital also includes Santa Monica UCLA Medical Center and Orthopedic Hospital.

Ronald Reagan UCLA's cutting-edge basic cancer research program allows oncologists access to new clinical trials and increases their "depth of understanding of the diseases being treated," according to John Glaspy, MD, director of the women's cancer program at Ronald Reagan UCLA's Jonsson Comprehensive Cancer Center. In addition, several ongoing collaborations with major cancer centers worldwide extend UCLA's access to research.

"Because it is such an intellectually rich work environment," Dr. Glaspy says, "we have been able to attract and retain the best cancer physicians who are interested in improving the lives of cancer patients and their families as rapidly as possible." [www.uclahealth.org](http://www.uclahealth.org)

**8. University of California, San Francisco Medical Center (San Francisco).** The UCSF Helen Diller Family Comprehensive Cancer Center at Mount Zion is the only center in Northern California to receive the designation of comprehensive from the NCI. It treats all forms of cancer from lung to prostate to AIDS-related cancers. It also offers specialized programs such as the Cancer Risk Program, a genetic counseling service for patients with a family history of cancer.

With new facilities, expanded programs and innovative research, the center ranks first in California and sixth nationwide in NCI research grants and is

home to pioneers in research into genetic, cellular and immune system causes and responses to cancer. The UCSF Children's Hospital also provides specialized care for young patients with cancer and blood diseases. [www.ucsfhealth.org](http://www.ucsfhealth.org)

**9. University of Texas M.D. Anderson Cancer Center (Houston).** The M.D. Anderson Cancer Center is part of The University of Texas System and one of the largest cancer centers in the world with more than 25 buildings in the Houston and Central Texas areas. In 2008, a survey from *U.S. News and World Report* ranked M.D. Anderson as the top hospital in the nation for cancer care. In 2008, M.D. Anderson treated more than 79,000 people with cancer, with approximately 27,000 new patients. In fiscal year 2007, more than 11,500 patients participated in the nation's largest therapeutic clinical research program, which explored novel treatments.

Michael J. Fisch, MD, medical director of M.D. Anderson's Community Clinical Oncology Program Research Base, attributes M.D. Anderson's success to values such as authenticity, compassion, discovery and passion. "People who work here are not just punching the clock," he says. "They really want to achieve the most for each person involved. We want to eliminate cancer whenever that is possible. We are looking for the best imaginable outcome." [www.mdanderson.org](http://www.mdanderson.org)

**10. Vanderbilt University Medical Center (Nashville, Tenn.).** The Vanderbilt-Ingram Cancer Center has been designated by the NCI as a comprehensive cancer center and includes hundreds of faculty and staff who are involved in cancer care, research, outreach and education throughout Vanderbilt University and the Medical Center campus. The center offers a variety of clinics, programs and cancer units and treats both adult and childhood cancers.

The Vanderbilt-Ingram Cancer center also offers a variety of support services, ranging from financial counseling to pharmacy services to providing a wig and hat bank for patients. It also has several cancer survivorship programs. The medical center receives more than \$150 million in annual research funding and has about 4,000 new cancer patients each year, with more than 65,000 outpatient visits annually. [www.mc.vanderbilt.edu](http://www.mc.vanderbilt.edu)

**11. University of Washington Medical Center (Seattle).** UW Medical Center is an internationally recognized referral and treatment center that offers everything from initial consultation and second opinions to comprehensive treatment, patient support services and follow-up care. In an effort to provide better care and to find a cure for cancer more quickly, the University of Washington, the Fred Hutchinson Cancer Research Center and the Children's Hospital and Regional Medical Center created the Seattle Cancer Care Alliance.

The UW Medical Center and the SCCA treat many types of cancers, including breast cancer,

endocrine neoplasia, gastrointestinal cancer, head and neck cancer, liver cancer, lung cancer, lymphoma and sarcomas. Other departments address gynecological oncology, neuro-oncology, oncology pain, pediatric oncology and prostate and genitourinary oncology. The UW Medical Center provides services at multiple locations throughout the Puget Sound region. [www.uwmedicine.org/Facilities/UWMedicalCenter/](http://www.uwmedicine.org/Facilities/UWMedicalCenter/) ■

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## Oncology Salary Statistics by Region

Here are statistics on the 2008 cash compensation earned by oncologists, as compared by region, according to the Integrated Healthcare Strategies 2008 *Healthcare Executive Compensation Survey* and supplementary IHS statistics.

### 20-25<sup>th</sup> percentile

National	\$204,000
North	\$277,000
South	\$230,000
East	\$246,000
West	\$209,000

### 50<sup>th</sup> percentile

National	\$232,000
North	\$374,000
South	\$341,000
East	\$312,000
West	\$239,000

### 75-80<sup>th</sup> percentile

National	\$277,000
North	\$424,000
South	\$425,000
East	\$521,000
West	\$259,000

### 90<sup>th</sup> percentile

National	\$404,000
North	\$506,000
South	\$989,000
East	\$576,000
West	\$286,000

*Source: Integrated Healthcare Strategies 2008 *Healthcare Executive Compensation Survey* and supplementary IHS statistics.*

*Integrated Healthcare Strategies offers comprehensive human resource consulting services to the healthcare industry. These services include physician services, executive total compensation, executive search, governance and leadership consulting, and human capital management consulting services. For more information please contact Steve Rice, executive vice president, or Chad Stutelberg, senior vice president, at Integrated Healthcare Strategies at (800) 327-9335 or e-mail [steve.rice@ihstrategies.com](mailto:steve.rice@ihstrategies.com) or [chad.stutelberg@ihstrategies.com](mailto:chad.stutelberg@ihstrategies.com).*

# Developing Centers of Excellence — Key Concepts, Strategies and Tactics

By Scott Becker, JD, CPA, and Lindsey Dunn

**T**he importance of developing outstanding programs, often referred to as "Centers of Excellence," in specific specialties has taken on new importance in critical specialties such as orthopedics, neurosurgery and spine, cardiology and oncology. This article discusses how developing a grand vision or plan comprised of clear goals can guide the development of a Center of Excellence. This article then examines specific strategies and tactics that can be used to implement such a plan.

Systems that develop dominant service lines can attract more patients, higher margins and more physicians. An outstanding or dominant service line can make a hospital a destination in an area of care and serve as a magnet for a range of opportunities. Thus, many hospitals and systems are constantly considering plans to develop a specialty Center of Excellence in conjunction with a group of physicians within that practice area. Such efforts, if developed well, can also provide physicians who are involved in the effort a competitive advantage in recruiting additional physicians and attracting patients.

## Physician-hospital relationships

There are currently a great number of changes evolving in physician-hospital relationships. These include substantial changes in the way in which hospital and physicians interact with each other. The overall landscape as to what types of relationships are being undertaken is moving very fast. These relationships again, in return to a 1990's strategy, include employment of physicians and acquisitions of practices as well as many variations in relationships. The employment efforts may prove to be beneficial or may again lead to serious financial problems for systems.

There are more legal concerns with regard to physician-hospital relationships than ever before. This is likely to complicate the development of Center of Excellence concepts. These concerns arise, for example, under the Stark Act, the Federal Anti-Kickback Statute, the Tax Exempt Rules and Regulations applicable to exempt hospitals, the False Claims Act and state laws. Every week there appears to be a report of a new case or settlement related to hospital-physician relationships or other payment relationships involving providers. These types of settlements relate not only to big-ticket, substantial investigations and behaviors but also to small seemingly inadvertent errors and mistakes under the acts.

A leader of a hospital or health system driving the development of a specialty-driven program must be able to defend his or her tactics both from a legal and business perspective. To a great degree, the question will ultimately come down to, "Is the system developing and engaging in a grand plan for a specific area of care?" or "is it simply utilizing tactics to capture referrals?"

## Develop an overall vision

A grand, overall vision or plan is critical for a facility or program to become dominant in a specialty area. Specific strategies are then developed in light of this plan. If strategies are not utilized in connection with a grand plan, it is much more likely that the efforts will fall short, from a business perspective. It also increases the chances that the implementation will simply look like payments for referrals as opposed to tactics aligned an overall plan.

## Clear and big goals

There are a few critical efforts that need to be made early on at the inception of a plan. First, the hospital or system and its physician leadership must define its overall goal — i.e., what is it trying to accomplish? For example, is the program trying to be the best orthopedic program in the

state? Is it trying to be a program that does more procedures of a certain type than any other system? Or, in contrast, is it trying to be a global leader in orthopedics and to develop an international brand in orthopedics or spine? Will the grand plan include a research or teaching function?

The system, in addition to this grand vision, may have other specific goals such as cost savings, improving trauma care, reducing wait times, providing all services or offering pediatric orthopedics. A grand vision with a clear goal is a prerequisite for determining the tactics that will be implemented by the parties to help the specialty program meet that goal. At the end of the day, the more that a system builds a grand vision and a clear plan as to what it wants to be known for, the easier it is to build tactics and strategies around those plans.

## Senior leadership must drive the plan

Hospital and physician leadership must not delegate the plan. Rather, the highest level of leadership should be involved in the plan from the very beginning and all the way through implementation and operation. The more that the system sees leadership such as the CEO and top physicians in the specialty involved in every meeting related to the plan, the easier it will be for the hospital and physicians to take action and gain buy-in throughout both systems. Delegating a critical plan and not involving key leadership throughout almost always leads to the ultimate failure of the plan.

## Role model hospital or program

As a system begins to form a concept or idea for its grand plan, it is very helpful to seek a role model hospital or center to use as a guide in developing its own plan. For example, can you find two or three hospitals or systems that have the attributes that your system or plan desires? Is there a great example that you could model your plan after? After determining a role model hospital or program and finalizing your own grand plan, one starts to determine tactics and strategies that will support and comprise the plan. Many of these will be similar to those used by the model system.

## Tactics and strategies

There are several tactics and alignment options that can be used to implement a plan. The tactics utilized range from full integration tactics to minimal integration efforts to a number of hybrid efforts. All tactics used should be targeted to meeting the big goals.

## Full integration

There are at least two core types of full integration models. The less common example of a full integration model is a whole hospital joint venture between a hospital and physicians. One example of this type of venture is the Institute for Orthopaedic Surgery in Lima, Ohio, between St. Rita's Medical Center and physicians. The Institute, a specialty orthopedic hospital, is majority owned by St. Rita's. However, physicians also have a financial stake in the facility. The Institute was originally developed by physicians.

Another increasingly common type of full integration model involves a situation where the physicians become employees of the hospital or a related subsidiary. For example, the dominant orthopedic group in Greenville, S.C., was acquired by a local hospital system a few years ago. This has become more common again in critical specialties. A few years ago the idea of large orthopedic groups or neurosurgeons being acquired by hospitals would have been immediately disposed of. Now, employment is often a critical part of developing a dominant service line.

## Semi-integrated models

Many parties pursue different types of semi-integrated ventures. These can include joint ventures for surgery centers, joint ventures for equipment and real estate, joint ventures which will provide management services and several other types of joint ventures. Here, one big distinction between true provider joint ventures such as those involving ownership of a whole hospital or a surgery center are that physicians can own an interest in the venture, derive the real profit from the venture and take real risk with the venture. In contrast, with equipment or real estate joint ventures, the payment to the lessor entity must be fixed fair market value and cannot vary based on the volume of business performed at the provider that the lessor leases to. In essence, there will not be any revenue or profit and loss congruence between the leasing entity and the provider that leases the equipment or real estate.

These semi-integrated models may be one dimension of an overall plan to develop a dominant service line.

## Compensation relationships

A third type of integration effort revolves around compensation relationships. These include many different types of arrangements. These can include call coverage arrangements, trauma arrangements, medical directorships, gain sharing arrangements, teaching relationships, research relationships, administrative/management relationships and several other types of payment relationships. The more that these are developed in light of a core, overall vision and clear plan for what the system desires to accomplish, the easier it is to reasonably justify having several different types of relationships with your physician specialists which the center of excellence is being built around. Almost all of these arrangements must be in writing and almost universally cannot vary or have payments tied to the

volume or value of referrals by the physicians. This can be a critical part of developing leadership in an area of care.

## Managed care strategies

A last general model of integration revolves around integrating and coordinating managed care functions. These can involve physician-hospital organizations that serve as managed care entity contracting ventures or bundled price initiatives. For example, a party might work on an alternative pricing model whereby the physicians and hospital jointly sell an entire package related to the top 10-20 most important orthopedic procedures or cardiovascular procedures. This has been experimented with in some circles and was experimented with to a greater level 10-12 years ago. However, with increased consolidation of payors, this approach again offers a way for providers to attempt to band together in the marketplace. As such, we are seeing an increase in this activity.

## Four more examples

Four other examples of working together with physicians towards development of a dominant position in a service area are as follows:

**Co-marketing and branding.** Certain systems have evolved outstanding co-marketing efforts with independent group physicians to jointly demonstrate the strength in the services and build a brand around those services. A great example of this involves the Rush University Medical Center and the orthopedic program at Rush. The joint marketing program which highlights and includes the physician leadership is outstanding and its overall focus on the Rush orthopedic program is excellent.

**VIDS approach.** Another concept that parties use to jointly align services is something that we have seen called a virtually integrated delivery system. Here, independent parties, such as a hospital and lead group of physicians,

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subject to certain anti trust requirements, work closely together to decide how they can approach the market in as aligned a manner as possible. This may include weekly strategic meetings on how they approach the market and several different implementation alternatives. This may or may not include various different financial relationships.

**Acquisition of practice.** We are again seeing many systems examine acquiring practices (and then employment of the physicians) to provide a beachhead in certain service lines. This again is an example of a full integration model. This may be aimed at having more critical mass in an area than any other competitor or to acquire specific expertise.

**Professional services agreement.** We see some situations where a hospital will buy a certain amount of professional services to provide them some contingent in a specialty where they are otherwise completely reliant on independent contractors or staff physicians. This may include a professional services agreement whereby a system buys the services of three full-time orthopedic physicians from a group. The group and the individual physicians are generally required to be on the contract pursuant to Stark Act and billing requirements.

## Choosing a few key strategies

Given that there are several different, major categories of ways to work with physicians to develop a dominant program and then numerous different tactics within those, we often recommend that a party choose no more than two or three key strategies to really pursue as part of establishing and implementing a plan. This might be the mix of a joint venture strategy together with employment models or a mix of employing some physicians but much more heavily relying on other types of compensation agreements with others to align efforts with the core goals. ■

*This is intended as a summary of some of the planning and strategies involved in developing a specialty-driven area of dominance or a Center of Excellence. Should you have further questions as to these issues, please contact Scott Becker at (312) 750-6016 or at [sbecker@mguirewoods.com](mailto:sbecker@mguirewoods.com).*

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# Centers of Excellence Achieved by Focus, Sweat and Determination

By Mark Taylor

**H**ospital executives leading nationally recognized superior programs offer a variety of tips for achieving those coveted designations, but they all sound like variations on the answer to that old Broadway joke: How do you get to Carnegie Hall? Practice. Practice. Practice.

Executives from four award-winning hospitals took different approaches to achieving distinction. And their advice reflects that. Hire good consultants. Listen to your doctors and patients. Study and improve your processes. Integrate the latest, evidence-based practices and protocols. Design the facilities to focus on the patient. Make it easier for physicians to practice there. Sweat the details.

"It's not one thing," points out Kevin Lundon, vice president of operations for 525-bed St. Joseph Hospital in Orange, Calif. "It's a whole series of commitments."

Mr. Lundon says his hospital achieved the ranks of *U.S. News & World Report's* "Top 50 Hospitals for Orthopedics" in 2007 and 2008 by committing to improvement. Mr. Lundon, who oversees orthopedics for St. Joseph, says the organization decided with its physicians how to distinguish themselves as the best in its region. "The goal was linking with our physicians and not just treating orthopedics as another procedure, but to develop it as a topnotch program."

Mr. Lundon says St. Joseph hired an experienced program coordinator to oversee the entire orthopedics continuity of care, from pre-op to post-op and follow-up, and built dedicated orthopedics, spine and joint specialty teams working exclusively within those areas.

"As they become more expert in orthopedic procedures, it allows for very smooth procedures and helps to make the patient experience the best possible," he says.

The program hired joint and spine surgical coordinators to work with the dedicated teams and coordinate supplies, equipment and implants, getting the programs off the ground in 2004.

"It takes years for those teams to coalesce and work well together," he says.

Mr. Lundon says surgeons need three things to be happy and successful: tools, time and teams. The hospital spent more than \$500,000 on the most advanced surgical tables, microscopes and a computerized joint system. "We made a commitment to be leading edge. We committed to our surgeons to allow them to be the most efficient practitioners they could be."

St. Joseph provided the high volume surgeons with PAs to assist them. The most efficient surgeons are allowed to "flip" two of the hospital's 31 operating rooms and patients are transported post-op to a 30-bed orthopedics unit staffed exclusively by a post-op nursing team. The hospital, which is one of only a few hundred designated a Nursing Magnet Hospital for nursing excellence, also invested in the "Smart OR" program.

The hospital's efforts weren't recognized only by awards. Orthopedic volume has increased by 25-40 percent and the program's contributions to the hospital margin have risen commensurately, particularly in the spine program. Mr. Lundon says St. Joseph logged the third highest volume of orthopedic procedures in California in 2008, performing 28,000 inpatient and outpatient surgeries, among them about 1,200 joint replacements.

"You need phenomenal surgical expertise and we're blessed to have high quality surgeons and great nurses," he says.

## Integrate health improvements throughout the hospital

Colleen Becker, director of peri-operative services for the Barnes Jewish Hospital Center for Bariatric Surgery, says the St. Louis center for treating obesity dates to the late 1970s. But it expanded its focus to include the entire continuity of care at Barnes Jewish, involving pre-counseling, dietary, social work, mental health and rehabilitation, as well as patient families and even former patients.

"We believe in working together to best manage the patient's needs," Ms. Becker says. "We saw this as an opportunity to improve outcomes and wanted to pursue the centers of excellence designation."

Barnes Jewish was designated a Center of Excellence by the American Society for Bariatric Surgery, which sets standards for care. "They left no stone unturned," she recalls.

To achieve designation, the organization pulled together a bariatric care committee that involved multiple services from throughout the hospital and involved other departments from surgery to oncology.

"We examined everything, from the kind of slippers we offered to the size of the bed and toilets and chairs in the cafeteria and the IV catheters, from shower curtains to ambulances and helicopters and the stretchers and tables we use," says Ms. Becker. "We looked at equipment and whether it met our needs. We realized that the bariatric pop-

ulation is throughout the hospital, not just in our center. We don't separate them out."

She says the results of those efforts manifested itself in new designs and influenced construction projects throughout the hospital, not just within Barnes Jewish.

"Our entire environment was evaluated for all patients, not just bariatric patients. It expanded our entire focus from the time patients enter as outpatients or in patients. We looked at every facet of how we provide care," she says. "The changes spanned the organization."

She says the organization's gastric bypasses have increased since 2005 and overall hospital patient satisfaction scores have risen as well. Surveyed bariatric surgery patients reported higher quality of life outcome scores.

"The program has helped boost the hospital overall and supports our hospital mission. Bariatric surgery isn't always profitable, but it's the right thing to do," she says.

## Treat well patients like healthy patients

Teresa Woodard, administrative director of rehabilitation and sports medicine for 262-bed Bon Secours St. Francis Health System in Greenville, S.C., says that program won distinction in *U.S. News & World Report* as one of the nation's best hospitals for orthopedics and joint replacement.

Ms. Woodard says St. Francis began by contracting with a consulting group, TVC, which advocates a very standardized approach to healthcare delivery. She says the hospital organized a multidisciplinary group that still meets monthly to develop care pathways and documentation templates for physicians.

"We'd always had a good program. But we were trying to get over that last hurdle to the next level and that's when we thought we needed outside help, a model to work from," she says.

Ms. Woodard explains that all the orthopedic patients except hip patients are well people choosing to have surgery. "And we treat them that way. There's a lot of emphasis on education, bringing patients in early so they know what to expect. We involved family members. We call the joint replacement program, Joint Camp."

She says the Joint Camp concept resonated with staff, physicians and patients, who were getting mobile sooner. "We branded everything. There were Joint Camp tent cards and T-shirts and

coaches' pins and group exercises. We tried to make it fun. There's a graduation ceremony."

The results have validated the investments. Joint replacement volume more than doubled from 704 in fiscal 2003 to 1,664 in 2008, the most in South Carolina for the fifth consecutive year. Total inpatient orthopedic volume grew as well, from 1,775 procedures in 2003 to 2,762 last year. The program also achieved the top decile in patient satisfaction at both campuses for orthopedics and earned a 2005 award from Premier for hip and knee replacement. Ms. Woodard says the contribution margin for inpatient orthopedics has increased 50 percent in the past three years and by 25 percent for outpatient orthopedics. HealthGrades has conferred its five-star ranking on St. Francis in hip, knee and total joint replacement through 2009 and ranked the hospital among the nation's top 5 percent for joint replacements through 2009 and the state's top orthopedics program. Regionally HealthGrades ranked St. Francis seventh in the Southeast in joint replacement and 18th in overall orthopedics through 2009.

Community outreach programs connect prospective joint replacement patients with St. Francis doctors and promote the program.

"We help them build their practices," she says. "The patients love it. Our scores average between 97-99 percent. Our market share has risen from 24 percent to 32 percent and the doctors appreciate what we've done for their patients."

### Starts with ground up and top down

Jeff Senall, MD, who chairs the department of orthopedics at the Central DuPage Hospital in Winfield, Ill., says its successful orthopedics programs starts from the ground up and goes the top down.

"We strive to be the best and everything we do is based on being in the top decile in country," Dr. Senall says. "That approach is taken in every hospital department, but certainly in orthopedics."

But saying it alone didn't make it happen. Dr. Senall says the orthopedics program worked hard to improve an already solid department.

"Our recent administrations have had a vision of being the best, of being a destination hospital. We were one of the first in the country to do joint replacements and we've always had strong clinicians," he says.

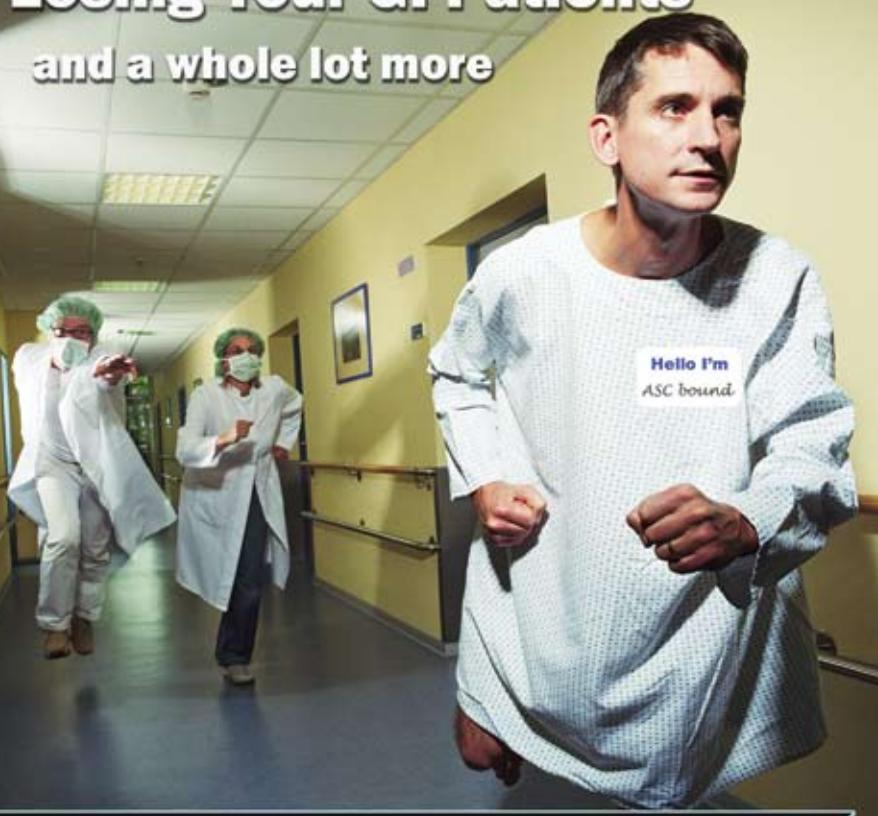
He says Central DuPage reexamined its processes, improving the turnaround time between cases so doctors who wanted to could perform more procedures. The hospital changed the way surgical instruments are processed to track them better and improve efficiency.

Dr. Senall says Central DuPage performed 1,459 joint replacements in 2008 and expects to do 2,000 this year, and the orthopedics department performed 4,400 procedures, accounting for about one-quarter of the hospital's 17,225 cases. Orthopedics accounted for 10.4 percent of revenue in fiscal 2007, and that figure is expected to rise to 11.3 percent in 2009.

"We are second in the state in the number of joint replacements and for years we've had a fellowship program training fellows from Rush University (in nearby Chicago). That was a big move for a community hospital and helped increase our volume in joint replacements. We're very lucky to be financially sound as a hospital to be able to provide the resources that our patients and doctors want and to make it easy for surgeons to practice here," he says of the program, which staffs 31 orthopedic surgeons from nine group practices. ■

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# 8 Ways Hospitals Can Prepare for Recovery Audit Contractors

By Mark Taylor

**B**y the beginning of 2010, U.S. hospitals and other healthcare providers will face something their colleagues in California, Florida and New York slogged through for three years, a new force in regulatory oversight called Recovery Audit Contractors.

And what they don't know can cost them.

Starting March 1, most Western and Midwestern states will be reviewed by RACs. By Aug. 1, Northeastern states will face RAC scrutiny and by Jan. 1, 2010, CMS is predicting the RACs will be operating in Southwest and Southeast states.

The RACs were created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, began operations in 2005 and were made permanent by the Tax Relief and Health Care Act of 2006. The RACs, during the original demonstration project, identified Medicare overpayments and underpayments of more than \$1.03 billion, which expanded in 2007 from the original three states to include Massachusetts and South Carolina. The RACs also collected \$187 million in contingency fees. More than 85 percent of the \$992 million in overpayments came from hospitals.

Healthcare reimbursement and legal experts say there are proactive steps hospitals can take to prepare themselves for the RAC reviews and any potential appeals they might file challenging the overpayment determinations.

**1. Look at previous RAC denials at other hospitals and learn where your hospital may be vulnerable.** Andrew Wachler, an attorney with the Royal Oaks, Mich., firm of Wachler & Associates who specializes in Medicare reimbursement appeals, says the bulk of payment denials and overpayment collections from the RACs have been in two areas: medical necessity and improper Medicare coding, particularly in the area of inpatient and outpatient hospital admissions.

"We're seeing a lot of inpatient admissions challenged and claims denied because they should have been billed as outpatient observations, which pays at a lower rate," Mr. Wachler says. "The RACs said that it was not medically necessary to admit the patient as an inpatient. But the standards are not always clear. CMS is taking the position that if an inpatient claim is denied, it won't even pay for an outpatient observation. But we disagree with their legal conclusion."

Suzanne Lestina, technical manager of revenue cycle for the Westchester, Ill.-based Healthcare Financial Management Association, says hospitals need to find their vulnerabilities and assess any potential financial impact.

"If you're a high Medicare hospital, you need to see where the RACs are focusing and determine the financial impact of denials in those areas," she says. "What is the risk to your services? If you conducted an internal audit today, what would you find that the RACs might find? Is your process in order and working right? Are you RAC-ready?"

**2. Involve your physicians.** Mr. Wachler says many of the RAC denials involved hospital admissions that were later questioned. "Most of those were short stay cases in which patients were only in the hospital for a brief period of time. It's more important now to evaluate those admissions and the hospital's admission process," he says. "That's why it's critical to have good, strong physician involvement to help educate other physicians on what's required in this admission process, how to document everything correctly and the types of surgeries that may have a preliminary default in one category of another."

By having a strong utilization review process for admissions, he says, the hospital can develop a defense when admissions are challenged. "They can say: 'We did what we were supposed to do.' You can't educate all of your admitting doctors: they're overwhelmed and will be paid the same amount with no real financial stake in this. But having a strong, established process with physician involvement can protect the hospital's interests."

**3. Establish a RAC team and coordinator to lead the process.** Rochelle Archuleta, senior associate director of policy for the American Hospital Association, says many hospitals have developed internal RAC teams to confront the challenge and respond proactively. She says some hospitals selected interdisciplinary RAC teams from compliance, risk management, finance, medical records and legal departments.

"That helps to make sure hospitals can respond to RAC requests for medical records and appeals in a timely fashion and to be prepared for areas likely to be targeted by them," says Ms. Archuleta.

She says that states that have established statewide tracking systems to monitor RAC correspondence and appeals activity will be ahead of the game. "CMS has only conducted one independent study of medical necessity decisions

and that small study found an unacceptably high error rate of 40 percent and execution problems by the California demo project RAC," she says. "That feeds our concerns about medical necessity denials."

Pat Wesley, regional director of revenue management for the five-hospital Northern Region of the Sisters of St. Francis Health Services in Hammond, Ind., agrees.

"I've redeployed one person on my staff to be coordinator for RAC information at all facilities in anticipation of this," says Ms. Wesley. "Until we get in there and see how it will play out, it's hard to get out the crystal ball and predict the future. We will have to make decisions on each denial, whether it's worth it to appeal. If they request 200 records, we may have to make that decision 200 times."

Ms. Wesley says her system has been educating hospital staff from numerous hospital disciplines, including medical records, billing, finance, compliance and the legal department.

"And we'll pull people from other duties if we have to fight any potential determinations," she says.

She says the hospitals work very hard to follow Medicare guidelines and bill appropriately.

**4. Establish a line of communication with your local RAC.** HFMA's Ms. Lestina says creating relationships with the RAC covering your region is one of the most important recommendations offered by HFMA hospital members in the RAC demonstration states.

"Hospitals need to determine the person who will be their internal contact and be sure the RAC communicates with that person. The RACs communicate in a number of ways, via e-mail, phone, letter and in person. Establishing a good partnership makes the process work better," Ms. Lestina says. "Hospitals from RAC demonstration states said that's what you should do first."

**5. Conduct self-audits.** The AHA's Ms. Archuleta says assessing a hospital's risk could prepare it for later RAC requests and denials.

She says the AHA is concerned about medical necessity reviews, in which RAC program "auditors 'second-guess' treatment decisions made by physicians in care delivered years earlier," she says. "We're concerned that auditors can be lacking in knowledge of Medicare payment guidelines and coverage criteria. There are bonuses for every denial found and there are incentives

to find an error, rather than to take the time to do a comprehensive review. It creates a guilty-until-proven-innocent scenario."

Ms. Archuleta says the AHA has a RAC-related educational program on its Web site at [www.aha.org/aha/issues/RAC/aharesources.html](http://www.aha.org/aha/issues/RAC/aharesources.html) and has launched a Web-based hospital survey program called RACTrac to allow hospitals to share their RAC review experiences.

She also points out that CMS offers a RAC-related outreach program at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac).

**6. Build a tracking mechanism.** Ms. Lestina says hospitals need to know what is happening internally and keep track of the running clock on any denied claims they hope to appeal. "It's important for hospitals to get their arms around this information so they are always within time frames of the appeals process. There is no practical cure for a late filing," she says. "The RAC denial process has strict deadlines, so tracking denials and appeals is important. Hospitals need operational infrastructure to track denials and appeals. If you appeal within a certain time, there is no withhold (by the RAC). During the demonstration project, the RACs took all the money upfront."

"But now, if you file and get to the first level within 30 days, they don't take the money," she says. "There are other deadlines in the process that are important to know. It's good to consult someone who's been through it."

She says a New York hospital association created a database for hospitals in that state, which has worked well for them.

Ms. Wesley says her system — The Sisters of St. Francis Health Services — has purchased a database to track information. "We have systems in place to audit what we're doing and verify that we're doing it correctly. This is just another layer on top of that," she says.

**7. Double-check the deadlines.** Ms. Wesley says once a hospital receives a determination of an overpayment from a RAC, it needs to review it carefully to see whether it agrees or not and intends to challenge it.

"Once they notify us, it starts the appeals process, which can be very time-consuming. But there are very specific timelines when you must supply records and if you miss the timeline, that encounter could be deemed 'inappropriately paid' and they (the RACs) will take back the money," she says. "It's very important we have systems and processes in place to turn around those requests very quickly."

#### **8. Don't be afraid to appeal if you're confident the claims were appropriate.**

Attorney Wachler says one reason the RACs have recovered nearly \$1 billion in overpayments is that the hospitals have not challenged their determinations often enough. "They've collected so much because hospitals haven't always appealed when they should have," says Wachler,

who has performed Medicare reimbursement audit defense work since 1980 and written extensively about the RAC process.

He says many hospitals have had claims denied and found deficiencies and think they don't have winnable cases. "My perspective is different when it comes to documentation," Mr. Wachler says. "If a hospital delivers a medically appropriate service, it should not go unpaid just because it did not dot every 'i' and cross every 't.' Documentation is important, but there are defenses that allow providers to appeal and prevail when they are in substantial compliance. I've seen providers not appeal millions of dollars on winnable cases because some of their documentation was lacking. Hospitals need all appropriate reimbursement in this environment. There are both legal and meritorious defenses and if you don't understand all of them, then you're leaving money on the table."

Ms. Lestina recommends reviewing each RAC denial thoroughly. "Don't assume that it's actually correct," she says. "There have been some questions about the RACs expertise on regulations and some instances where reviewers had used outdated information. Hospitals need to be smarter than the RAC auditors."

The AHA's Ms. Archuleta points out that CMS's own Jan. 2009 data shows that 45.2 percent of appealed denials are overturned in the hospitals' favor. She notes that while hospitals that have appealed stand a good chance at success, many hospitals don't appeal. "They don't pursue them because they are too costly and require infrastructure to deal with old records," she says. "Appeals take 18-24 months and cost between \$2,500-\$5,000, and that's a heavy burden, especially when talking about claims paid two to three years prior." ■

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## Recovery Audit Contractors in Brief

- Launched with a three-year demonstration project in 2005.
- Pilot found \$1.03 billion in improper payments, \$992.7 (96 percent) from overpayments collected from healthcare providers and \$37.8 million (4 percent) in underpayments. The pilot RACs, who were paid on a contingency basis, collected 20 percent finders' fees of \$187.2 million.
- Pilot program, which was authorized by the Tax Relief and Health Care Act of 2006, to expand to all states beginning in 2010.
- CMS selected four RAC contractors in Oct. 2008, each responsible to finding and collecting improper payments for roughly one-quarter of the country. More states will be added later. The four RAC contractors are: Diversified Collection Services of Livermore, Calif., which will work in Region A (Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont); CGI Technologies and Solutions of Fairfax, Va., which will work in Region B (Indiana, Michigan and Minnesota); Connolly Consulting Associates of Wilton, Conn., which will work in Region C (Colorado, Florida, New Mexico and South Carolina) and HealthDataInsights of Las Vegas, Nev., which will work in Region D (Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming).
- Even after subtracting the costs of refunding underpayments and overpayments that were denied on appeal, the RACs still returned \$693.6 million to the Medicare Trust Fund. Most overpayments, about 85 percent, were collected from inpatient hospital providers, while 6 percent came from rehabilitation facilities and 4 percent from outpatient hospital providers.
- CMS said most overpayments came when providers submitted claims that did not comply to Medicare coding or medical necessity policies.

Source: CMS Reports on Recovery Audit Contractors, June and Oct. 2008.

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# Hospital Employment of Physicians: What Works and Does Not is Very Clear

By James Hamilton, FACMPE

**T**hrough market observation it can be seen that there is a strong reemergence of physician employment by hospitals and health systems. The strategic logic for this reemergence is similar to the past — i.e. gain market share through primary care access or for other markets primary care as well as specialist employment is an imperative for institutional survival or service line protection. Hospital or health system boards and leadership that are employing or considering physician employment strategies should be concerned over the appropriate manner of implementation or effectively managing/growing the strategy. The strategy of physician employment is past the experimental stage so that lessons learned of what works or does not work is very clear.

## Four implementation or growth strategies that work

The following is an identification of four critical success elements when employing physicians.

### 1. Physician recruitment

There are numerous poor approaches for physician recruitment. It has been seen that less attention is paid to the process of physician recruitment than buying capital equipment even though the cost of operating a physician practice can be significantly higher than many capital investments. Also the hiring practices tend to be reactionary versus strategically planned. Effective recruitment should be matched against a criteria or proof of need. In the mechanics of recruitment, the physician recruiter's job is to fill the position. If you are not a high profile client you might be getting B or C level candidates.

Given this back drop, it can be a buyers-beware market. This is particularly true for the medium to smaller hospitals. Knowing how to read the resume is a starting point of knowing your candidate. The unexplained movement in residency programs, gaps in the resume history as well as short stays in any employment situation could be red flags needing further investigation. Also, the best candidates will be very astute to the amenities of recruitment. If future call colleagues are not present in an interview process, this will be viewed negatively by the best recruits. Lastly, make certain that the spouse or significant other is well tended in the recruitment process. Success in the long-term retention of physicians is highly dependent on family wellbeing and fit to the community.

### 2. Physician contracting and compensation

The general content of today's physician employment agreements are much more uniform versus what was seen in the early days of physician employment. The major fracture is a poorly designed process of physician contracting and determining compensation. For those that have worked with physicians in the professional practice environment, it is widely understood that the compensation methodology determines the health and foundational culture of working with physicians. The employing organization should invest time and money into getting this part of physician employment well positioned. If employment agreements reflect individual compensation negotiations and special deals versus a consistent over arching compliance proof method and philosophy of compensation, this is a path for failure in a physician employment strategy. If your physician turnover rate is high, this will be one of the top reasons why. It is also costly to maintain individual contracts. Additional costs will be reflected in resources to support contract compliance as well as lost goodwill in contract terms not being met.

### 3. Appropriate leadership and infrastructure

Hospitals and health systems continue to use the traditional hospital infrastructure to manage employed physicians. Adherence to this structure will move the organization to a decentralized or service line orientation of provider and staff management. In most cases, this leads to a condition of hospital culture consuming strategy. In all situations where this has been seen, it has been a highly sub-optimized or failed physician employment strategy. For the majority of the organizations, hospital management staff does not possess the appropriate knowledge and tools to manage physician practices.

In the market this does not appear to be a lesson learned. The successful path for hospitals and health systems is to have the physician group as a service line unto itself or set aside in a separate organizational structure. Since physician employment has been so prevalent in the market, finding administrative leadership to manage in this environment can be achieved.

Also, physicians need to govern themselves. Reflective of "best practice" organizations' authority guidelines, physician compact and code

of conduct can be established so that physician governance groups will function at a highly efficient and productive level.

### 4. Understanding the economics of the strategy

There are real economic danger points that have recently been seen in the hospital employed physician market. By pursuing a decentralized or service line orientation of physician employment, the cost of the practice operations is buried in the financial reports of the service line. The philosophy becomes, "if the service line is profitable with the practice costs included, then I am ok with my strategy." Adhering to this philosophy buries millions of dollars of losses and bad decision making in some organizations. This also significantly diminishes the capital formation ability of the organization. For best-of-breed operations, the financial operations of the employed physician practices is clearly understood, benchmarked and maximized for operational performance.

By economically knowing your operations at this level, you can significantly maximize revenue and control costs. Financial tools are available to assist leadership with this level of reporting.

The last economic consideration is that professional practice revenue cycle management should not be managed through the hospital infrastructure. In all markets where this has been seen, millions of dollars have been lost by using hospital policies and procedures for physician revenue cycle management.



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## Compendium of do's

The knowledge and information to successfully manage an employed network of physicians is present in today's market. The previous listing of thoughts is a high-level presentation of issues that need to be appropriately managed. Success is gained by effectively managing the details. The following compendium of do's is only the beginning point of successfully employing physicians by a hospital or health system.

### Physician recruitment

- Build a model of physician recruitment that is not reactionary but is tested against the strategic plan of the organization. Reactionary employment is costly.
- Get to know the red flags in a physician resume. Set high standards of expectations. It is costly and time consuming to hire poorly.
- Be astute to the amenities of the interview process. Call colleagues and spouse/significant other considerations are vital to long-term physician retention.
- Employing physicians is more costly than the purchase of most capital equipment. Give the employment process the same attention to detail that you would when making a major capital investment.

### Physician contracting and compensation

- Make it a given that all physician employment agreements will be the same (except for compensation).
- Establish the scope of negotiated offerings that would be afforded to any candidate (i.e. sign on bonuses, moving expenses).
- Establish an overarching philosophy and methodology in physician compensation. The effective management of physician compensation sets the trust, retention and cultural level for the employed physician group.

### Appropriate leadership and infrastructure

- Establish an organizational structure for the employed physician practices. Decentralized or service line management of physician practices will significantly sub-optimize or create financial failure.
- Employ administrative leadership that has experience in managing physician practices. Hospital management staff cannot adequately lead in the professional practice environment.
- Provide a governance structure for the physicians that include authority guidelines, physician compact and code of conduct. Physicians need involvement in the decisions that will affect their professional practice.

### Economics of the strategy

- Set, as a given, the need for financial tools that provide benchmark information so that informed management decisions can be made.
- Establish revenue cycle management that is not under traditional hospital management or its policies and procedures. ■

*Mr. Hamilton (jhamiltonamm@aol.com) is principal executive with Somerset Health Care, which provides extensive services in the employment of physicians by hospitals and health systems as well as successful venturing physician alignment strategies. Somerset Health Care has developed financial tools to benchmark the economic performance of employed physician networks as well as physicians in the private practice setting. These tools include financial reporting, coding analysis, revenue cycle performance and fee schedule analytics. Mr. Hamilton has worked in senior leadership roles for single and multi-specialty groups, large integrated health systems and single- and multi-hospital community/religious-based systems. Learn more about Somerset Health Care at <http://healthcare.somersetcpas.com/healthcare.htm>.*

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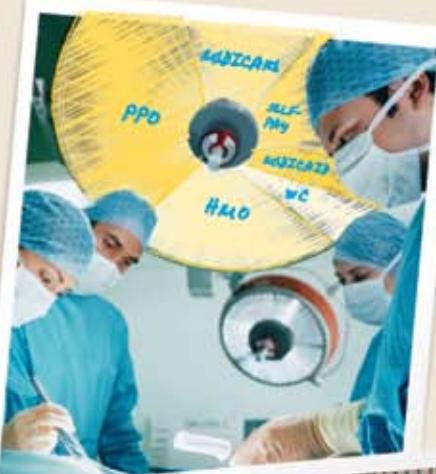
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